CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

6 December 1997

NI follows suit with 2.4pc imposition

Better local networking call for 'New Age'

Multiples taking bigger share of contracts

Update: don't panic over peanut allergy

Dove rides the storm over pay at PSNC

Business Trends survey: a case for prescribing

Minimum wage will have major impact in-store

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The National Minimum Wage Bill aims to provide a 'wage floor' to prevent unduly low wages. It will establish a single minimum wage which applies to all workers above compulsory school age. There are limited exemptions, but community pharmacies will not be one of them. It will cover both full- and part-time staff, and will involve a modicum of record keeping by employers. As with all 'good ideas' the NMW has its problems. First, some bench marks: the NJIC rates for pharmacy shop assistants range from £2.09 per hour for a 16-year-old to £3.21 for 19 years and over. These are the accepted minimums: many pharmacists pay above these rates. But nearly 40 per cent of managers in a *C&D* survey conducted earlier this year said some of their staff would be affected if the NMW was set at £3.50. USDAW, the shop workers' union, is calling for a minimum of £4. A labour force survey in the spring suggested the lowest 10 per cent of employees earn £3.17 per hour or less; while the lowest-paid 25 per cent had earnings of £4.20 or less.

The NPA cautions that the NMW could hurt the very people it is supposed to help. With pharmacy margins already under pressure, an expanding salary budget is the last thing managers will want to contemplate. Laying off staff is a short-term solution, but for healthcare businesses that provide advice and a personal service, it is no long-term answer. For pharmacy proprietors, an NMW set at an unrealistically high level will not serve their business interests – nor the public interest. For part-timers aiming to come under the National Insurance lower earning level, an increase in their wage might lead them to seek a reduction in hours. But the 'doom and gloom' merchants will have to wait until the low pay commission recommends a rate next May to see if their predictions come true. Now is the time for contingency planning.

CHEMIST & DRUGGIST

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REGULARS

Northern Ireland follows suit with 2.4pc imposition

The Department of Health and Social Security has imposed a 2.4 per cent increase on the global sum for pharmacy contractors in Northern Ireland.

The settlement is based on an expected 3 per cent increase in prescription numbers. There will be an increase in the dispensing fee of 1.5p from 87p to 88.5p. The professional allowance is unchanged staying at £1,400 per month. The graduated payment scale for pharmacies dispensing between 800 and 1,299 prescription items per month remains.

PCC had asked the Department to take into account the larger number of smaller pharmacies in the Province, compared to the rest of the UK, and the headline inflation of 3.7 per cent. However, settlement was determined with a letter sent on November 19, and is much in line with the Scotland, England and Wales impositions. PCC will discuss the implications at its meeting on December 11.

"We are all disappointed and very annoyed with the outcome," says PCC secretary Terence Hannawin. "It is the first time in many years that we have been in dispute with the Government over negotiations."

An additional dispensing fee of 43p for dispensing Schedule 3 drugs including temazepam has been made, as happened in last year's settlement for England and Wales. Mr Hannawin points out that there is no new money, just a redistribution.

"We are fearful for the future of pharmacy," said Mr Hannawin. "We feel that the quality of services will deteriorate." He also believes there will be a reduction in the number of pharmacists prepared to offer new services: "It seems pointless for pharmacy contractors to become involved for no extra remuneration."

Retail park fails 'neighbourhood' test

Oxfordshire Health Authority has turned down two applications for pharmacy contracts, made under the 'neighbourhood' ruling, as the applicants' stores were in a retail park, rather than a shopping centre.

Both Boots the Chemists and Tesco had applied for pharmacy contracts at stores on the Eastern By Pass Retail Park at Cowley, Oxford. But last week, were told by the HA that their applications have been refused.

Setting out the reasons for rejection, the Authority said its Pharmacy Group decided that pharmacies on the retail park would be of no benefit to patients of nearby surgeries, and there was no evidence that there was not already an adequate provision of pharmaceutical services. It also found there was no evidence that customers visiting the retail park either sought or required the provision of pharmaceutical services.

Tesco pharmacy superintendent Mike Rudin has responded to adverse comments in local newspapers about its applications policy (*C&D* last week, p6) saying :"I like to think that what we are doing is what the public likes. You can't expect people to park their car and then drive off to find pharmacy services elsewhere."

He believes that the neighbourhood rulings by Justices Tucker and Collins deal with the principles and not with the site.

Tesco has made, or is intending to make, about 140 applications based on the neighbourhood ruling, and already has 190 in-store pharmacies. "Whenever we open a Tesco pharmacy we have never knowingly closed a pharmacy," he added.

Anti-drugs views sought

Keith Hellawell, the UK's first anti-drugs co-ordinator, has written to a wide range of organisations and experts, seeking their views on how best to deal with Britain's drug problem.

He is asking for thoughts on:

- developing a consistent approach to drug enforcement, treatment, prevention and education
- the effectiveness of existing government-funded anti-drugs activities
- reorganising programmes and funding at central government level
- making local partnerships work better
- involving the private sector and others in anti-drugs work.

Mr Hellawell will present a report to ministers next spring.

Views sought on research priorities

The Pharmacy Practice Research Resource Centre has produced a consultation document, proposing an agenda for research that needed to be carried out on the role of pharmacists in self-medication.

It is the first of three consultation exercises which aim to establish research priorities for pharmacy practice, as recommended by the RPSGB's Research and Development Task Force. Three research programmes will then be set up, each co-ordinated by a multidisciplinary expert panel. The first agenda, 'Self-care and the pharmacy', is defined as 'self-management of minor ailments and the use of non-prescribed medicines'.

An expert panel met in October to identify possible themes for research. These include the reasons why people decide to self-medicate or seek healthcare advice, the influence of pharmacists' own health beliefs on product selection, barriers to pharmacist involvement in advice on minor ailments, evaluation of outcomes, and attitudes of customers and other health professionals towards pharmacists.

The PPRRC is inviting opinions on the priorities of the research issues identified and any other high priority areas that should be included; it would also like to know about studies conducted on areas identified as lacking in adequate research. The deadline for comment is January 9. A final report, containing a 'prioritised' agenda, will be published next spring.

- Copies of the document are available from PPRRC, School of Pharmacy and Pharmaceutical Sciences, Oxford Road, Manchester M13 9PL (tel: 0161 275 2342; fax: 0161 275 2416).

Pharmacists look for extra NHS responsibilities

Pharmacists like the idea of taking on limited prescribing responsibilities, according to the latest *C&D* Quarterly Business Trends Survey, sponsored by AAH Pharmaceuticals. They feel equally confident in repeat prescribing for certain conditions where treatment has been initiated by a GP.

And there is evidence that community pharmacists are concentrating more on their image as healthcare providers, with a significant number increasing the shelf space they give to OTC medicines. For details turn to p26.

OTC emergency contraception survey planned

Dr Keith Holden, a primary care pharmacist for Hartlepool General Trust, is planning an investigation into whether the 'morning after pill' should be available OTC.

If his year-long project is granted funding by the Northern Region Health Authority, he will send out questionnaires to 4,000 pharmacists in the northern region next May. Pharmacists will be asked if they feel suitably qualified or are willing to get involved in providing this type of clinical service.

He is hopeful that he will be able to secure funding, adding that "the deregulation of emergency contraception has not been explored and one of the Health of the Nation targets is to reduce the pregnancy rate by half in under-16s by the year 2000".

Dr Holden will be assisted by a biological anthropologist, who specialises in reproductive health, and a psychologist, who will develop and analyse the questionnaire.

Following the pharmacists' survey, Dr Holden would like to investigate how the 'at risk' behaviour of teenage girls could be stopped and to see if they would accept community pharmacies as a source of emergency contraception.

Local contacts review urged

The Royal Pharmaceutical Society's president, Peter Curphey, has called for pharmacists to urgently review their local network of professional contacts.

The call follows a RPSGB survey of over 500 pharmacists which highlighted potentially serious gaps in the communication network of community pharmacists.

"I would urge all pharmacists to review their network of contacts and start to bridge any gaps without delay. I am especially keen to see all Society branches getting in touch with their LPC colleagues and pharmaceutical advisers," says Mr Curphey. "There is a wealth of information and support to share and issues of mutual interest that can appropriately be discussed."

Most LPCs have formal annual (43 per cent) or quarterly (32 per cent) meetings with their local medical committees in spite of most LPC secretaries reporting no contact with GP fundholders (66 per cent) and non-fundholders (72 per cent). Communication between LPCs and branches could be improved: Over 30 per cent of the Society's branch secretaries report no contact with LPC colleagues, and 24 per cent of LPC secretaries have no, or annual, contact with branches.

Contact with patients' groups is patchy, with fewer than 20 per cent of Society branches having any contact with Community Health Councils, but over half of LPCs and pharmaceutical advisers meet CHCs at least once per year.

There is a low level of interaction between community pharmacists and senior members of health authorities in spite of the key role of health authorities in shaping local healthcare.

NPA branch secretaries lead the way in developing links with social services, with just under half reporting attempts.

Within the profession, pharmaceutical advisers and CPPE tutors report the best networks with other pharmacists.

Scotland to lose PHS leaflets

Pharmacists in Scotland will no longer receive leaflets from the Pharmacy Healthcare Scheme, following the Health Education Board for Scotland's continuing refusal to pay.

In England and Wales the scheme is funded by a contract with the Department of Health, and the Northern Ireland Department reimburses the costs of supplying NI pharmacies. Apart from a one-off payment of £10,000 last year, the Health Education Board has been unwilling to fund supplies in Scotland.

As a gesture of goodwill, PHS has been sending the material to Scottish pharmacies in the hope that the situation would improve, but this has now become too expensive.

Pharmacists in Scotland who are concerned about losing a source of health promotion leaflets should write to Dr Andrew Tannahill, Health Education Board for Scotland, Woodburn House, Canaan Lane, Edinburgh EH10 4SG.

Drug recall for Emcor 10mg

Merck Pharmaceuticals is recalling Emcor Tablets 10 mg, batch number B120042. The Medicines Control Agency issued the class 2 alert on Monday after Merck reported finding a blister strip labelled Emconor Tablets 5mg BN 96127, expiry August 2001 in a carton labelled Emcor 10mg. For information on the replacement of stock, contact Mrs L Doggett at Merck on 01462 670097.

New PCC secretary responds to criticism

Terence Hannawin, the newly appointed secretary of the Northern Ireland Pharmaceutical Contractors' Committee (PCC) has responded to critics, saying that their lack of understanding of negotiations and their unrealistic expectations was extremely unhelpful.

Speaking at the Ulster Chemists' Association AGM, he announced PCC's intention to develop a strategy that would give it more focused direction in the future.

He identified three key dilemmas currently facing PCC. The first was the new pharmacy services that a small number of pharmacists were providing. As there was little hope that these would be remunerated, and yet, enthusiastic contractors were providing them unremunerated with Government approval, it was not appropriate for PCC to be supporting such initiatives. Yet PCC, due to this lack of support, was being viewed as backward looking. This was not the case. PCC was, he said, as supportive of change and development of the profession as anyone, but the Committee had to be realistic in its expectations of new funding for new services.

The second dilemma facing PCC was that agreements it had made with HPSS, that were in the best interests of the majority of contractors both short term and long-term, may be detrimental to a minority.

The third dilemma was the PCC's stance on contract limitation. Should PCC support a reduction in the number of contracts? Northern Ireland had many more contracts per head of population than the rest of the UK. A reduced number of contracts would further strengthen the remaining contractors but might play into the hands of dispensing doctors. He insisted that the biggest threat to limitation of contracts was pharmacists, and he criticised some pharmacists who were, in his opinion, abusing the process and even in some cases putting up "stalking horses".

He praised all those who had made a significant contribution to the new Northern Ireland dispensing doctor guidelines. He felt confident that within a short time, those dispensing doctors still in existence would either have stopped dispensing or would be dispensing for a much reduced list of patients. This was something all contractors should be grateful for.

● Incoming UCA president Donald Moore was thanked by outgoing president Sam Wilkinson for all his hard work and personal sacrifices during the year representing the Association.


Terence Hannawin

Pharmacy numbers static

The number of community pharmacies (9,773) in contract with health authorities in England on March 31 was virtually the same as a year earlier.

During the 12 months to March 31, 63 pharmacies opened up and 48 closed down. In the past five years, 295 have opened and 269 closed, according to statistics published last week.

There was a slight trend to multiple ownership. Sixty per cent of all pharmacies were independent, 39 per cent belonged to chains of five or more and 1 per cent operated from health centres. The corresponding percentages for March 31, 1996, were 63, 36 and 1 respectively.

Half of all pharmacies dispensed more than 3,251 prescription items a month in 1996-97; one quarter dispensed fewer than 2,228 and one-quarter dispensed more than 4,760 items. The median figure was 3,179 in 1995-96. The total number of items dispensed in 1996-97 was 443,192,000 at an average net ingredient cost of £8.11, 6 per cent higher than the year before.

In England, as a whole, there were 199 community pharmacies per million population on average. Kensington, Chelsea and Westminster HA had the most pharmacies per million population (416) but they dispensed the least prescription items per month (average 1,422). In March 1997, 256 pharmacies received payments under the Essential Small Pharmacies Scheme. A total of 3,664 pharmacies were receiving payment for advice to 13,035 residential and/or nursing homes.

● *Statistical Bulletin: 'General Pharmaceutical Services in England 1996-97'.*

Dobson's concerns about pharmacy

Health secretary Frank Dobson is concerned that pharmacists' knowledge is not being fully utilised, says LPC secretary David Kent following a meeting with Mr Dobson this week.

Mr Kent, Camden & Islington's LPC secretary, and LPC chairman Alan Spivack and vice-chairman Michael Long, met with the health secretary at the Department of Health in London for an hour.

Mr Dobson showed enthusiasm for electronic links in the NHS and was keen to implement them between health authorities and primary healthcare professionals.

The LPC pharmacists highlighted the problem that prescription numbers, on which the practice allowance is based, are a poor measure of the work that pharmacists in the capital are doing. They also discussed how to take the new roles forward, protect its existing role and make the profession thrive in areas of low prescription numbers.

EPIC stance on postgrad education

Bob Gartside, chairman of the Employee Pharmacists In the Community group, has called for future compulsory postgraduate education to be classed as in-service training, in EPIC's new newsletter.

Employee pharmacists should not be expected to give up 30 hours a year of scarce leisure time in order to remain on the register, says Mr Gartside. Nevertheless, problems of funding remain to be solved.

MSF, the union to which EPIC is affiliated, produced its first newsletter for employee pharmacists in the community last month. In future, it plans to publish them once every two months.

MCA proposes changes to rINNs

A consultation letter, MLX/241, on changing the names of certain medicines to the recommended International Nonproprietary Name has been sent out by the Medicines Control Agency.

The letter lists the name changes needed to comply with European law (Directives 65/65 and 92/27/EEC) to ensure consistency of the names of medicinal products throughout the EU (see *C&D*, October 25 p29). It is proposed that there should be a five year phasing in period where the British Approved Name will be used with the rINN. Changes to leaflets and labels will have to be made by December 31, 1998.

Copies of the letter are available from the MCA's Information Centre at Room 1206 Market Towers, 1 Nine Elms Lane, London SW8 5NQ, telephone 0171 273 0352. Responses are sought by January 9.

Cash limits in NHS white paper

Cash limits and a new institute for clinical effectiveness to be proposed in the NHS white paper next week will lead to more generic prescribing by general practitioners, according to ministerial sources.

The institute will offer doctors advice on the most cost-effective as well as clinically effective drugs and treatments available on the NHS with the implication that doctors should follow their lead in their prescribing patterns.

The white paper is heavily influenced by Treasury thinking, and ministers are expecting practitioners to prescribe more generic drugs to remain within their budgets which will be cash limited for the first time. Alan Milburn, the health minister, has denied he is introducing rationing through the White Paper, and that clinicians will remain free to prescribe the drugs they believe are best for their patients.

But the clear implication from the white paper will be that GPs are expected to do more to curb the burgeoning £4 billion NHS drugs budget. The key proposal to merge the general medical service budget with primary care budget will bring cash limiting down from hospital budgets to GP surgeries for the first time.

The BMA has warned GPs cannot be allowed to run out of cash to prescribe NHS drugs to their patients before the end of each financial year. Whitehall sources have indicated that there will be sufficient flexibility in the budgets to avoid patients having to shop around to find a GP with funds for the scrip pad.

The drugs industry is expected to challenge the drive towards more generic prescribing and will argue that money could be saved if doctors were better informed, but that does not necessarily mean going for the cheapest drugs available. New research among patient groups and clinicians has shown that patients being treated for AIDS, mental illness and heart disease were not receiving the most cost-effective treatments.

Cash limits, which have applied to fundholders in the past, will drive GPs to prescribe more generics, and the white paper could result in more OTC treatments being sought.

The white paper will propose the abolition of the internal market; fundholders will be replaced by locality commissioning groups of primary care practitioners, who will be given more power over the hospitals in the delivery of patient care.

The publication of the white paper was delayed until December 9 to allow it to be launched by Tony Blair, who is attaching his own stamp of authority to the document. The announcement of the so-called 'fraud buster' who will crack down on alleged fraud in prescriptions by pharmacists and GPs was also delayed until after the publication of the white paper. No reason was given but DoH officials denied they had run into difficulty in finding the right person for the job.

The growth in the generics market may compensate the generics industry for the loss of extra income from the patient pack initiative, which was withdrawn by Alan Milburn, the Health Minister, because of the unexpected high cost – an estimated £60m over three years. Mr Milburn made it clear in a letter that Government still had to find an alternative system to meet an EU directive on patient packs, but the Department is no nearer clarifying its intentions.

Society designates new Fellows

The Council of the Royal Pharmaceutical Society has agreed to designate eight members as fellows this week. They are:

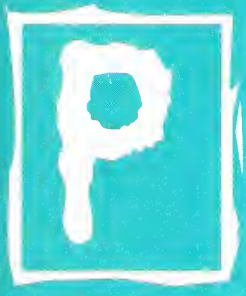
- for the distinction in the practice of pharmacy – Gerald Collins of Pinner, Middlesex and James Smith of Newcastle Upon Tyne
- for distinction in the profession of pharmacy – Charles Butler of Reading, Berkshire, John Jolley of Newbury Berkshire, Ian Simpson of Oxford, and David Temple of Cardiff
- for distinction in the practice and profession of pharmacy – Gillian Hawksworth of Huddersfield and Mary Tompkins of Colchester.

LPC views sought on PSNC election

Local Pharmaceutical Committees are being asked whether they would support PSNC elections being postponed until after the next LPC conference.

Croydon LPC secretary Andrew McCoig is contacting about 60 'undeclared' LPCs following the announcement that Hemant Patel has received support from 34 LPCs for his proposed review of PSNC (*C&D*, November 22 p5). Mr McCoig believes it would be reasonable for the election to be postponed if sufficient LPCs give PSNC a mandate to alter the constitution.

Sometimes



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Topical Reflections

Frustration fuels internal divisions

The furore over Hemant Patel's attempts to review the structure and function of PSNC continues to dominate the political pages of the pharmaceutical press, with acrimonious debate that publicly exposes the irreconcilable divisions of community pharmacy. I view with increasing despair the destructive effect of such a vicious civil war and wonder what has sparked off such a passionate reaction.

The answer, of course, is sheer frustration. The frustration of a contract that can no longer satisfy the professional aspirations of many community pharmacists. However, although the present contract is unfair, it is amazingly cost-effective for the Government. It is not going to willingly change a piece work system that is so easy to control for that of a contract based on professional service, where the financial consequences are unpredictable.

No amount of beating of breasts will change the minds of politicians grappling with the harsher realities of a health service whose resources can never match demand. Hemant deserves his review because PSNC has been complacent and autocratic, but we should not be lulled into false hope that the result will produce a panacea.

The Government will continue with its own agenda of more of the same with fewer resources. The dream of a fairy godmother disguised as a new contract is just that, a dream that with the dawn becomes reality, where the law of the jungle will continue to govern the evolution of community pharmacy.

Reports of my demise are premature

I have always maintained that my main commercial strength is the personal way I run my business. I was delighted to have this confirmed by David Williams, founder of 'Encouraging Excellence', a national management network programme, when he spoke recently to 50 independent pharmacists in Newcastle (*C&D* November 29 p6). He exhorted his listeners to become "customer obsessed" and to this I can only say: "Hear, hear!"

My survival depends on the quality of my service, where the most important reason for customers' patronage is trust. They shop with me because they wish to do so and no amount of multiple company training will overcome that advantage.

I not only survive in my secondary position, but I can even, modestly, show steady growth. I am under no illusions about the pulling power of the local superstores, but they still remain cold and impersonal. Dotty, by contrast, greets every customer by name and I offer professional advice at the same time as enquiring after the whole family.

The predatory activities of Tesco *et al* in trying to gain new contracts are at last recognised by some commentators as being motivated by greed (*C&D* November 29 p6) and public sympathy could quickly follow. The independent community pharmacist has become a bastion of local community service, and I believe that reports of its impending death have been greatly exaggerated!

Has G-W given up with its agency scheme?

The attitude of Glaxo Wellcome towards its independent customers continues to amaze me. I cannot remember the last time I was visited by one of its representatives. I have learnt not to become overstocked with its products and even its iniquitous discount structure is of little consequence.

I am pleased to be able to obtain consistent supplies of parallel imports Zantac, Zovirax and Lamictal at very competitive discounts and also most of G-W's inhalers, either in UK livery or repackaged to an acceptable standard. I am happy, my customers are happy, and I no longer have to worry about wholesale thresholds.

Glaxo Wellcome could identify the unusual buying patterns that affect my business and then attempt to rectify the inconsistencies. That the company does not is a clear indication to me that it has effectively abandoned its much vaunted agency scheme. It should now officially accept its failure and return to the trading systems that still adequately serve the rest of the pharmaceutical industry.

N IRELAND NOTEBOOK

Where's the Vision?

I was impressed by the Pharmaceutical Society's 'Vision 2020' when it was published last spring. Discussing the matter with fellow contractors there appears to be a lot of pragmatism in the plan and I believe it has the general support of the profession.

Were the plan to be implemented, contractors are the group it would impact on the most and we therefore need a clear input into this vision, or else it is doomed to failure. The PCC must ensure that contractors' interests are protected in this matter.

Contractors have always been the rate limiting step in modernising the profession. I want modernisation as much as anyone, but in real terms must state my position unequivocally. I have a considerable investment in pharmacy, and to change radically the way it is practised could significantly damage that investment.

There have been many valiant attempts to modernise pharmacy in the past 20 years. All were well intentioned and all failed simply because they were not sufficiently sympathetic to contractors.

PCC must ensure contractors' interests are protected

Following Nuffield, there was the call by the Royal Pharmaceutical Society to abolish the final check on a prescription. A packed meeting of contractors put an end to that folly. Contractor power will do the same to any nonsense that comes from 'Vision 2020'.

A modernised service that shifts the focus of control from the contractor, who funds the service, to the pharmacist, who provides it, is one that most contractors will resist unless suitable guarantees are given.

When a contractor was the practising pharmacist, modernisation would have been an easy process, but pharmacy is now a multiple profession. This is not to say that development of the vision is impossible.

Yet I have heard little of 'Vision 2020' following its initial high profile launch. My pre-registration student was invited to a meeting about the Vision in November, but beyond that the subject has been quiet. Perhaps the young Turks at 73, University Street are running out of steam and are losing sight of their goal.

Written by a practising Northern Ireland community pharmacist

Power Performance Profit

"The most effective products still carry that magic 'P' in the corner"

Xrayser, C&D, 1 November 1997

And the most exceptional of these become unrivalled market leaders - like IBULEVE.

'Pharmacy Only' brands give Pharmacies the Power to compete with mass retailing. P lines deliver high Performance to improve customer loyalty and increase your Profits.

IBULEVE has transformed Pharmacy business in topical pain relief, like no other Product. A sensationally successful brand backed by sustained heavyweight Promotion.

IBULEVE is exclusively yours to sell.

IBULEVE. Brand leader with a Passion

COUNTERpoints

Larkhall's campaign coincides with Eastenders' story

Larkhall Green Farm is supporting its Cantassium Micro Folic Acid with a £30,000 advertising campaign this month.

The two-week campaign is timed to coincide with the spina bifida story line in 'Eastenders'.

The company organises National Spina Bifida Week for the Association for Spina Bifida and Hydrocephalus, to raise awareness of the role of folic acid in the development of the foetus.

It donates 10p from the sales of Cantassium Micro Folic Acid supplement to the charity.

Ceuta Healthcare. Tel: 01202 780558.

Rimmel's new hair colour designed in mascara form

Rimmel International is launching a new hair mascara.

The product is designed to brush in and shampoo out. More widely spaced bristles than a normal mascara brush allow the formulation to coat hair evenly.

It is available in six shades – bronze, gold, champagne, royal blue, aqua and burgundy.

Presented in a clear barrel with gold graphics and a blue pearlised cap, it retails at £2.99.

Rimmel International Ltd. Tel: 01233 625076.

Quest launches echinacea

Quest Vitamins has added an echinacea product to its herbal food supplement range.

Quest Standardised Echinacea contains 294mg extract providing 4.4mg cichoric acid, which is equivalent to 500mg herb powder.

Echinacea is a herb which is known for its role in maintaining immune health.

The product retails at £9.99 for 60 tablets (trade £5.67).

Quest Vitamins Ltd. Tel: 0121 359 0056.

New face promotes Head & Shoulders

The new face for Procter & Gamble's Head & Shoulders range is Jenny Powell, star of TV show 'Wheel of Fortune'.

Jenny will appear in new advertising for the brand from mid December, and she will help consumers re-evaluate the brand as a regular-use shampoo.

For the first time, the company has signed up a professional hair stylist (Ray Nightingale) to endorse the brand in TV advertising.

Procter & Gamble will be investing £8.5m in media support for Head & Shoulders during the next year.

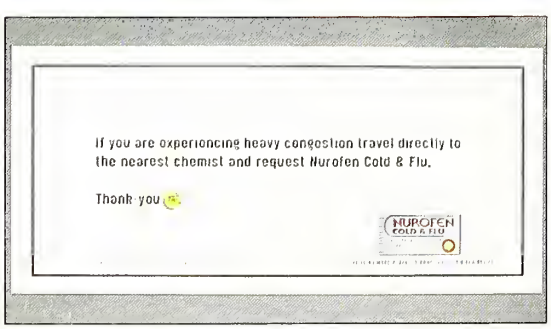
Procter & Gamble (Health, Beauty & Cosmetics) Ltd. Tel: 01932 896000.

Nurofen cures congestion on the London Underground

Crookes Healthcare is supporting its Nurofen Cold & Flu with a winter advertising campaign on TV and on the London Underground.

The stormy cliff face TV commercial will be on air until January and the amusing tubecards will appear on the Underground throughout February.

The tubecards emphasise the multi-symptom relief that the product offers with light-hearted statements such as: 'If you are experiencing heavy congestion, travel directly to the nearest chemist and request Nurofen Cold & Flu. Thank you.'



The campaign is part of a £10m consumer support programme for the total Nurofen brand.

Crookes Healthcare Ltd. Tel: 0115 9539922.

Pregaine to complement Regaine

Pharmacia & Upjohn has launched Pregaine, a "high quality shampoo designed to complement the use of Regaine".

Pregaine is available as a clear, hypo-allergenic gel, and a frequent use shampoo designed to clean thinning hair. Both products retail at £3.50 for 200ml. They are pH balanced, and formulated to add volume and improve manageability.

Pregaine does not contain minoxidil, nor does it include many of the commonly used ingredients, such as silicones, which may impede absorption of Regaine or damage new hair growth, says P&U.

Pharmacia & Upjohn. Tel: 01908 661101.

Redmond adds all over body wash

Redmond Products is launching an all over body wash in its Aussie range.

Made with natural ingredients, the product has a neutral pH and comes in two variants.

Moisturising formula is enriched with honeysuckle and white ginger to clean and moisturise.

Refreshing formula contains arnica and oak bark to refresh and cleanse all-in-one.

Retail price is £3.49.

Brand Managers Ltd. Tel: 0181 286 6688.

Eucryl's campaign gets personal

LRC Products is supporting its Eucryl smokers' toothpaste, toothpowder and breath freshener with a £250,000 three month campaign.

Starting this month, the advertising features a series of advertisements in the style of personal column announcements.

It announces a variety of tempting offers – from a £50,000 job as a beer taster to an offer of marriage to a 98-year-old lottery winner. But the punchline in every case is that only non-smokers need apply.

Targeted at smokers in the 18-35 age group, the key message is that the brand will help eradicate the stains and odours caused by smoking.

LRC Products Ltd. Tel: 01992 451111.

Educational message for Rhinomer

Novartis Health is supporting its new isotonic seawater spray for active nasal lavage with a promotional campaign throughout the winter months.

Dr Mike Smith is broadcasting on local radio stations throughout the country in the promotion.

The company is taking an educational approach to highlight the product's benefits.

Jane Lowrie, marketing manager at Novartis, says: "There appears to have been some confusion about this product. It is a medical device and not reimbursable."

Rhinomer is available in three forces – Rhinomer Baby, Rhinomer Medium and Rhinomer Strong. Trade price for a single unit is £3.57 (retail £5.60).

Novartis Consumer Health UK Ltd. Tel: 01403 210211.

Power Performance Profit

"The most effective products still carry that magic 'P' in the corner"

Xrayser, C&D, 1 November 1997

And the most exceptional of these become unrivalled market leaders - like BAZUKA.

'Pharmacy Only' brands give Pharmacies the Power to compete with mass retailing. P lines deliver high Performance to improve customer loyalty and increase your Profits.

BAZUKA has transformed Pharmacy business in verruca and wart treatment, like no other Product. A sensationally successful brand backed by sustained heavyweight Promotion.

BAZUKA is exclusively yours to sell.

BAZUKA. Brand leader with a Passion

New baby face for Rinstead

Schering-Plough will be supporting its Rinstead Teething Gel with a £1m marketing campaign in 1998.

Eight-month-old Heaven Cordina-Wilson will be featured in a nationwide poster campaign and point of sale material.

Heaven was the winner of a Rinstead competition which was promoted solely through pharmacies. her prize was a year's modelling contract with the company.

During 1998 Rinstead will be supported by trade and consumer press advertising.

Schering-Plough Ltd. Tel: 01707 363636.

Swiss sales

St Ives Laboratories is spending £4m on TV support for its Swiss Formula hair, body and facial products, beginning on December 24.
St Ives Laboratories Ltd. Tel: 01256 357222.

Name change

Rhône-Poulenc Rorer has changed Dioralyte Plain to Dioralyte Natural to reflect the product's lack of additives and colours.
Rhône-Poulenc Rorer Ltd. Tel: 01732 584000.

Calpol is top of the class

Warner Lambert's Calpol was voted the most essential family pharmaceutical product for the second year in a row at the 1997 *Mother & Baby* awards last week.

Also taking away awards were:

- Avent Isis breast pump (best new item of feeding equipment)
- J&J Baby Breatheasy (best skincare product)
- Sudocrem (best nappy cream

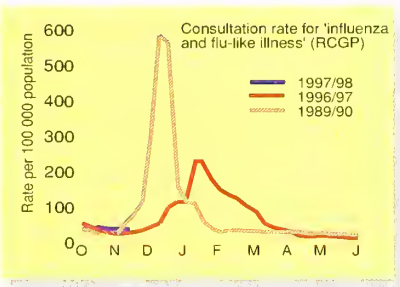
The event at the Park Lane Hotel was hosted by commedienne Maureen Lipman (left), who presented the award to Calpol product manager Julie Stott.

Christmas closing times...

- **Bioglan Laboratories** will be closed for business on December 25, 26 and January 1 and 2. On December 29, 30 and 31, the company will process orders received as normal. For delivery before Christmas, order by December 17.
- **Glaxo Wellcome UK's** full medical information service will close at 4.30pm on December 24 and re-open at 8.30am on January 5. On December 29, 30, 31 and January 2, a skeleton medical information service will be available from 9.30am to 4.30pm.
- **John Richardson Computers (JRC)** will operate normal working hours over Christmas and the New Year, closing only on December 25, 26 and January 1.
- The offices of the **Proprietary Articles Trade Association (PATA)** will be closed from December 23 until 9.00am on January 5. (Answering service – tel: 01923 211647.)
- **Polyfarma** will be closed from noon on December 24 until December 29. The company will also be closed on January 1. Orders placed before noon on December 24 will be delivered on December 30.
- **Roche Products** drug information department will not be staffed from 12.00 on December 24 until January 2. Only emergency calls can be handled during this period (tel: 01707 366000). Roche Prescription Medicines Order Processing Function will not be available from noon December 24 until January 2. For emergency orders on December 29, 30 and 31, tel: 01707 365635.
- **Sanofi Winthrop** will be closed from December 24 until January 2. Orders before Christmas may be placed on December 18 with deliveries no later than December 24.
- **Schering Health** will be closed from noon on December 24 until January 2. The last despatch for Betaferon will be December 18, recommencing after the New Year on January 5.

PHLS

Information updated weekly by the Public Health Laboratory Service, London



Summary

Into December and once again consultation rates for flu and flu-like illness remain below baseline levels in England, Wales and Scotland. Two cases of flu have been isolated since last week, one in central England and the other in the north. The situation in the rest of Europe remains unchanged.

Respiratory infections on the increase?

As the weather turns distinctly wintery across most of the country, the consultation rate for aggregated respiratory diseases increased slightly to 849 per 100,000 consultations in the last week of November, up from 802 the previous week. RSV (respiratory syncytial virus) infection figures are rising rapidly, with 711 reports England and Wales in the week ending November 28 compared to 434 the week before. RSV is linked with the sharp outbreak in acute respiratory disease which occurs annually in the late autumn. However, the number of *Mycoplasma pneumoniae* infections has dropped to 27 compared to 72 reported the previous week. Initial symptoms resemble flu, with malaise, sore throat and dry cough. Acute symptoms usually persist for a week or two followed by spontaneous gradual recovery.

Data from the PHLS (Communicable Disease Surveillance Centre, Virus Reference Division, CDSC Welsh Unit), the RCGP and Scottish Centre for Infection and Environmental Health

ON TV NEXT WEEK

Alka-Seltzer XS: All areas
Beechams Flu Plus: All areas except U, CTV, C4, GMTV
Benylin: All areas
Benylin 4-Flu: All areas
Braun Sensation: All areas except CTV, GMTV
Day & Night Nurse: All areas except CTV, C4, GMTV
Fetish: All areas
Gaviscon Advance: All areas
Meltus: STV, B, G, C, Y, CAR, GMTV, Sat
New Clearasil complete: All areas
Nurofen Plus: All areas
Pantene: All areas except GMTV
Prosport: Sat (Sky Sports)
Rimmel 1000 Caresses No Transfer Foundation: All areas
Tixylix: All areas except C4
Vicks Sinex: All areas except U & C4
Vicks VapoRub: All areas except U
Vicks New Vaposyrup: GTV, STV
Wella Experience: C4

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Power Performance Profit

"The most effective products still carry that magic 'P' in the corner"

Xrayser, C&D, 1 November 1997

And the most exceptional of these become unrivalled market leaders - like OTEX.

'Pharmacy Only' brands give Pharmacies the Power to compete with mass retailing. P lines deliver high Performance to improve customer loyalty and increase your Profits.

OTEX has transformed Pharmacy business in the treatment of hardened ear wax, like no other Product. A sensationally successful brand backed by sustained heavyweight Promotion.

OTEX is exclusively yours to sell.

OTEX. Brand leader with a Passion

NPA slams 2.4 pc imposition

The National Pharmaceutical Association Board has condemned as unacceptable the NHS pay settlement of 2.4 per cent imposed by the NHS Executive.

At its meeting last week, the Board considered the decision to be unrealistic as it was set against a volume increase of 2.8 per cent. It was also said to be demoralising for community pharmacists, given the apparent enthusiasm shown by the new administration for pharmacy – particularly by Frank Dobson – and its desire to make better use of community pharmacies in the delivery of local healthcare services.

The remuneration imposition may also have an impact on the National Minimum Wage. The Board has already made one submission to the Low Pay Commission highlighting the financial difficulties facing community pharmacists and asking that any introduced wage be both realistic and manageable.

With minimum wage legislation about to be laid before Parliament, the Board agreed that a further letter should be sent to the Low Pay Commission. The NPA would like to see a minimum wage set at a level below NJIC rates, otherwise many pharmacists would have difficulty in complying and could be exacerbated by the "miserly" NHS remuneration imposition.

The imposition may also have been a factor in the low response to the NPA North West Conference, which had to be cancelled because of poor ticket sales (*C&D* November 15, p4).

The Board heard that several pharmacists had indicated they were no longer prepared to listen to speeches extolling the valuable contribution being made to the NHS by community pharmacy, on the back of another derisory pay award.

Packaging The NPA is to ask the Medicines Control Agency to make it a requirement that the Association reviews and approves packaging of certain medicines before they are launched onto the market. This arrangement would apply initially only to medicines with a low therapeutic ratio, but it is envisaged that it would be eventually extended to all medicines.

There is concern that it is becoming increasingly difficult for pharmacists to identify readily the strengths of certain medicines. Some patient packaging prevents the contents from being seen, and there is also concern that manufacturers are using packaging to emphasise the company rather than the strength of the product.

Building the Future The Association is to request a meeting with the Royal Pharmaceutical Society to discuss the latest Pharmacy in a New Age document, 'Building the Future', launched in September.

Registration of Pharmacy Premises Fees The Board was pleased that NHSE has reviewed the proposed increases in premises registration fees, and accepts the revised increases for registration, retention and restoration of 2.3 per cent, 2.4 per cent and 2.3 per cent, respectively. The Board had objected strongly to plans to introduce increases of 3.1 per cent, 3.65 per cent and 3.4 per cent which it considered excessive.

Information Department Plans were discussed to further improve access to the NPA Information Department in 1998. This includes making greater use of the Internet, making more use of journals and reference books available on CD ROM and continuing the programme of staff training.

CFC-free The Professional Development Department will consider developing a programme to help pharmacists manage the transition from CFC to CFC-free monitored dose inhalers, at a local level. This could include protocols for pharmacists to work with doctors, and looking at whether it would be an appropriate therapeutic area to include in the NPA's model for a prescribing support service. While supporting in principle the European Parliament's proposed phase out of CFCs in monitored dose inhalers, the Board has several concerns about the transition arrangements.

Chemical gloves A supplier of appropriate chemical gloves has been found following a recent Health and Safety Executive report which recommended the wearing of chemical gloves when handling coal tar preparations. The gloves will be available from the second week in December from the NPA Sales Office.

Consultant calls for central funds for expensive drugs

A consultant paediatrician believes that decisions on NHS funding of expensive new drugs should be made by a national expert advisory committee, rather than at local level. There could even be central funding of high cost specialist care, said Dr Steve Conway, St James Hospital, Leeds.

At the hospital's cystic fibrosis unit, he said, hours of professional time were spent arguing the case for Pulmozyme which cost about $7,000 a year per patient but, if successful, it could save at least a third that amount in reduced need for intravenous antibiotics as well as improving the patient's quality of life.

Because there were no long term contracts, doctors had to remake a case for each patient every year and cost-effectiveness was difficult to measure. Dr Conway thought staff at specialist CF centres were uniquely equipped to assess the impact of new treatments, whereas medical advisors to purchasing authorities had varied backgrounds and could not be expert in all fields.

He called for better funding, with separate CF contracts and single budgets for CF care.

Dr Roberts stands down

Dr David Roberts, chairman of the Dispensing Doctors' Association, has decided not to stand for office when the association becomes a limited company, but he will remain a member.

Elections to the board will take place on January 15, 1998, when the association starts to function in its new form. Nominations for the ten directors were open until November 30 and there will be a postal vote. A chairman will be elected by the directors, rather than the members.

Fifteen members attended the association's annual meeting on Sunday. Fewer than 15 per cent of the total membership of 1,750 responded to a postal vote, in which the majority rejected proposals that the chairman should be elected by a postal vote, and should have an approved list of duties. As DDA members had to agree to join the new company before voting, DDA Ltd has only about 260 members, although a recruitment drive has started.

Dr Roberts said, this week, he was disappointed by the size of the vote and the apathy of members. "The old DDA did a great deal for dispensing practice in this country and I regret recent events which have tragically weakened the association and are likely, for better or worse, to bring it closer to GMSC's point of view."

Apotheker-Kalender for 1998 available

The German pharmacy magazine *Deutscher Apotheker Verlag* has published a full colour calendar with illustrations relating to the history of medicine and pharmacy.

Each of the 12 pictures is A3 sized and has notes in German and English. The calendar starts with an early 19th century Thomas Rowlandson caricature of 'The Quack'. Other artefacts include the medicine kit of a Zurich field surgeon, the Nußdorf carved altar with SS Cosmas and Damian, and a photograph of the 18th century dispensary in the University of Zurich Museum.

The calendar measures 49cm x 49cm and is priced at DM48. Further details are available from Deutscher Apotheker Verlag, Buchhandlung, Postfach 10 10 61, 70009 Stuttgart, Germany. Tel: +49 711 25 82342, fax +49 711 25 82290.

Uncertainty over generic quality in Ireland

Half of the 130 Irish pharmacists interviewed for a recent prescribing review believe that some generic drugs are unreliable.

The finding came in a survey to determine whether annual target budgets for expenditure on drugs have influenced the quality of prescribing to General Medical Services patients in Eire.

Most pharmacists (68 per cent) believe that the policy, which has similar aspects to fundholding in the UK, has had a negative effect on the quality of prescribing, and that the introduction of novel drugs to GMS patients has slowed down.

Half reported a loss of earnings as a consequence of the scheme, and 90 per cent reported an increased costs due to the requirements of keeping larger stocks of diverse brands.

The same number think there has been a reduction in the quality of care for vulnerable groups and a third cited experiences where patients were thought to have been denied necessary medication as a result of the policy.

Sixty per cent think that prescribing for GMS patients has become inferior to that provided to private patients.

Codeine Phosphate Inj

Aurum Pharmaceuticals has introduced Codeine Phosphate Injection 60mg/ml in 1ml (ten x 1ml ampoules, £16.50). It will be distributed in the UK by: McGregor Cory, Middleton Road, Banbury, Oxon, OX16 8RS. Tel: 01295 277888. For technical enquiries contact: Aurum. Tel: 01403 786781.

New from Generics UK

New products from Generics UK include: Doxycycline 50mg (28, £7.27); Phenoxymethylpenicillin Potassium (Penicillin V) Tablets 250mg (1000, £16.44); Co-Codamol tablets (100 blister pack, £1.17; 500 Securipack, £5.87); Co-Dydramol (100 blister pack, £1.39; 500, £6.95) and Haloperidol Tablets 1.5mg (100, £4.59; 250, £11.48), 5mg (100, £13.08; 250, £32.70), 10mg (50, £12.47) and 20mg (50, £22.66). Generics (UK) Ltd. Tel: 01707 85300

Wrong number

The freephone order number for the Pasteur Mérieux MSD Vaccine Direct service, given last week, should have been 0500 106410.

Biovital range

Ownership of Biovital Bottle (200ml and 325ml) and Biovital tablets (60 and 120 pack) has transferred to: Roche Products Ltd. Tel: 01707 366000.

Optil 60mg

Trinity Pharmaceuticals has launched Optil (diltiazem) 60mg tablets (84, £12.10). Trinity Pharmaceuticals Ltd. Tel: 01484 604506.

GW withdraws Romozin

Glaxo Wellcome has taken a voluntary decision to withdraw troglitazone (Romozin) the latest treatment for Type 2 diabetes, following reports of serious hepatic side effects.

Troglitazone, the first of a new class of medicines – the thiazolidinediones – was launched in the UK on October 1 (see *C&D* **Script Specials**, October 4) and has been prescribed to 5,000 diabetics in the UK.

The decision to withdraw the product was taken following reports of liver problems in US and Japanese patients who had been taking the drug for more than three months. Six deaths and over 130 cases of liver damage, including severe hepatocellular damage, hepatic necrosis and hepatic failure, have been reported from the 370,000 patients who had been on the drug for more than three months.

Doctors are being advised that no further patients should be started on troglitazone therapy, existing patients should be recalled and switched to an alternative treatment, liver function tests should be carried out on patients, and any patients experiencing signs or symptoms of liver dysfunction should be referred to specialists.

After reviewing all available data Glaxo Wellcome says it "hopes to be in a position to make recommendations regarding the use of troglitazone".

Glaxo Wellcome had been marketing and distributing the drug in the UK under licence from Sankyo, the Japanese company which developed the treatment. Warner-Lambert, which holds the US marketing rights for the drug, has not as yet withdrawn troglitazone from the US market.

Further information on the withdrawal can be obtained from Glaxo Wellcome's freephone helpline (tel: 0800 413828). The British Diabetic Association has a careline (tel: 0171 636 6112) which diabetic patients can also contact if they have queries about the drug.

Share prices have been affected by the announcement (see **Business News**, p29).

Clozaril update

Novartis Pharmaceuticals has printed a revised data sheet for Clozaril (clozapine), updating the following data:

- the precautions section has been expanded with particular reference to the management of patients who experience febrile neutropenia and liver disorders
- drug interactions has been expanded to include more information on clozapine metabolism and information on drug interactions with fluoxetine
- it is now recommended that blood monitoring should continue for four weeks after complete discontinuation of therapy
- the side effects section has also been expanded to include additional information on the combination of Clozaril and valproate therapy, tardive dyskinesia, thromboembolism, liver disorders, acute pancreatitis and interstitial nephritis.

Amias: a new AII antagonist from Astra

Astra Pharmaceuticals and Takeda UK have launched Amias, a new angiotensin II antagonist indicated for the treatment of hypertension.

Amias (candersartan cilexetil), differs from some other AIIAs in its ability to non-competitively inhibit the AT_1 receptor. It is long-acting with tight binding to and slow dissociation from the AT_1 receptor and shows dose-dependent efficacy over its full dose range. The suggested starting dose is 4mg once daily and the usual maintenance dose is 8mg once daily up to a maximum of 16mg once daily. In cases of renal or hepatic impairment the initial dose should be 2mg daily, which is then adjusted according to response.

Adverse effects include headache, upper respiratory infection, back pain, dizziness and nausea, although these tend to be mild and transient compared with placebo.

No clinically significant drug interactions have been identified but due to experience with ACE inhibitors the manufacturers recommend monitoring of serum lithium levels. Its bioavailability is unaffected by food intake.

Amias is said to show efficacy comparable to agents of other classes – 4-8mg is as effective as enalapril 10-20mg once daily and 16mg is statistically more effective than losartan 50mg, the first AII antagonist to be approved for use in hypertension.

Amias tablets are available in four strengths: 2mg (7, $3.00); 4mg (7, $3.35; 28, $13.40); 8mg (28, $15.75) and 16mg (28, $19.10). **Astra Pharmaceuticals Ltd. Tel: 01923 271000.**

NOW YOU'LL SEE IT WORKING

ALL NEW TV SPONSORSHIP CAMPAIGN

The first ever sponsorship of Regional Weather bulletins on GMTV
4 SLOTS A DAY, 5 DAYS A WEEK, DECEMBER - MARCH

MASSIVE COLOUR NATIONAL PRESS CAMPAIGN

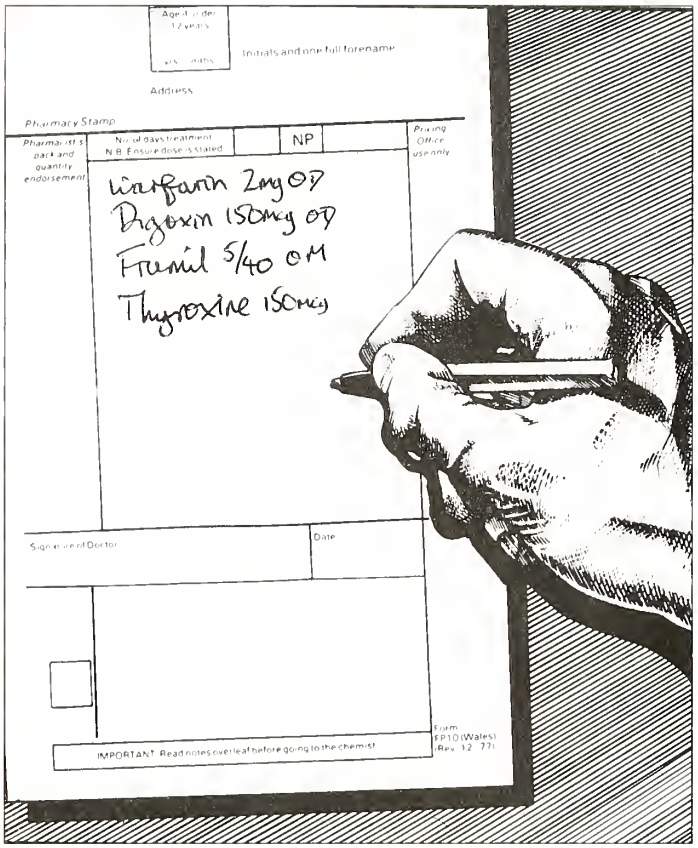
It's no wonder Covonia is Britain's fastest selling pharmacy cough medicine *
With that distinctive taste and warm comforting glow, people are convinced that they can actually feel Covonia working.

And with the massive new campaign, you'll see it working on sales and profits as never before.

ORIGINAL FORMULA COVONIA COUGH MEDICINE

Presentation: Oral Solution. Each 5ml contains 7.5 mg Dextromethorphan hydrobromide BP and 2.5 mg Menthol BP.
Indications: For the symptomatic relief of non-productive coughs such as those associated with the common cold and bronchitis. **Dosage and administration:** Adults and children over 12 years old, two 5ml spoonfuls. Children aged 6 - 12 years, one 5 ml spoonful, the dose may be repeated after 4 hours if required. Not recommended for children under 6 years. **Contraindication, warnings, precautions:** Contraindication: Liver disease. Hypersensitivity to any of the ingredients. Patients receiving MAOIs. Persistent or productive cough. **Warnings:** Covonia normally works without causing drowsiness, but care should be taken as rare exceptions can occur. If symptoms persist consult your doctor. Do not exceed the stated dose Keep all medicines away from children. **Precautions:** Driving - Dextromethorphan may cause dizziness and drowsiness rarely Cimetidine may delay the elimination of dextromethorphan. **Use in Pregnancy:** No data. However, dextromethorphan and menthol have been widely used for many years without apparent ill - consequence. **Side effects:** Constipation, gastro-intestinal discomfort, nausea, vomiting, dizziness and drowsiness may occur rarely. **Legal Category:** P **Licence Number:** PL 0240/5033 **Date of Preparation:** October 1997. **Pack Size:** 150ml **Price:** 150ml - £2.29 **Licence Holder:** Thornton & Ross Ltd. Huddersfield, HD7 5QH, England.

* Nielsen Retail Audit Pharmacies excluding Boots. July/August 1997



A GP phones to ask for your advice. He has an 85-year-old patient with heart failure who is well controlled on current therapy. He has just been diagnosed as having gout. The GP has three questions concerning the prescription

Questions

1 How should he treat this in view of the patient's condition? The patient must have frumil.

2 Will colchicine be safe?

3 Will it be safe to give allopurinol long term?

Answers

1 Gout is a disease which occurs predominately in men beginning in middle age. Both loop and thiazide diuretics can decrease the renal clearance of uric acid, therefore leading to hyperuricaemia and then on to the painful acute attacks of gout. The frumil the man is taking is likely to be exacerbating or causing his gout. Normally you would consider removing the causative agent but in this case the patients heart failure is well controlled and the GP is justifiably unwilling to start changing therapy in case the patient becomes uncontrolled.

2 The treatment of acute gout can be with a NSAID (eg indomethacin) or colchicine. Indomethacin is normally the drug initially considered but the GP is concerned about any interaction with the warfarin. The worry about the interaction may be displaced a little. There is an interaction between indomethacin and warfarin leading to an increased warfarin effect, but this is a rare but unpredictable effect. More commonly when prescribing indomethacin in a patient with warfarin is the risk of gastrointestinal bleeding which is potentially dangerous in a patient on warfarin. Therefore, the treatment of his acute attack with indomethacin has a double risk.

In such circumstances, colchicine is the drug of choice and in this patient may be a better choice to treat his gout. Colchicine is given to treat the pain and is taken 1mg initially then 500 micrograms two to three hourly until pain relief or to a maximum of 10mg over three days or until vomiting or diarrhoea occurs (BNF). Elderly patients are susceptible though to the cumulative toxicity of colchicine hence more prone to side-effects. If this patient receives colchicine he should be monitored and counselled for such an event.

3 Allopurinol is used for prophylaxis of gout. It should not be given within the acute gout phase as it may exacerbate the disease. Therefore it is recommended to be started about four weeks after the last acute attack (BNF). Allopurinol is known to interact with warfarin to cause hypothrombinaemia. This reaction is rare and unpredictable but potentially dangerous and close monitoring of the INR will be required.

LETTERS

Closures on oral liquid antibiotics

It has been my practice for the past year to replace all metal sealed caps on oral antibiotics with child resistant closures. The value of this practice was borne out recently when, during a locum coverage, I took a telephone call from a somewhat distraught mother, whose child had drunk a quantity of Augmentin suspension taken from the fridge by the child.

The mother correctly pointed out:

- the lack of a CRC closure
- the instruction on the carton to store in the fridge.

She pointed out that her fridge door does not have a lock on it. Does any domestic refrigerator?

She added that she keeps all medicines in a locked medicine cupboard, which is above child reach height.

In view of all that she had said, there was no criticism that I could make of her household medicine policy.

As pharmacists, we have a responsibility to protect all medicine users from accidental misuse, especially children. The answer here seems to be either:

- to replace the manufacturer's metal cap with a CRC. I strongly recommend removal of the remaining metal ring at the same time
- transfer to a standard 100ml medicine bottle with CRC.

For generic liquid antibiotics, the second option would seem to be the only answer if the product is packed with a plastic tear open cap. Other generics have sealed metal caps which can be treated in the same way as suggested for Augmentin, while others do have child resistant caps.

The choice of which to buy lies with the pharmacist. Both the tear open plastic cap and the metal sealed caps should be rejected. I am confident manufacturers will not accept the resultant loss of business, but will soon change to bottles with child resistant caps.

Here is an opportunity to show mothers and other customers that pharmacists do care and perhaps one in which we in Northern Ireland can lead the way.

Norman Hall
Holywood, Co Down

PHARMACY update

Peanuts and panic: coping with anaphylaxis

Dr Richard Pumphrey, at the immunology unit of St Mary's Hospital in Manchester, looks into the most severe reaction to allergy, anaphylaxis

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1074), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JANUARY 10, PROVIDES ONE HOUR'S CONTINUOUS EDUCATION

OBJECTIVES

- To know the difference between anaphylaxis and allergy
- To understand the mechanism of anaphylactic reactions
- To be aware of the different presentations of adrenaline
- To be able to train patients in the safe and effective use of adrenaline pens

Even minute traces of peanut can cause a life-threatening reaction

Familiar allergic disease includes asthma and hay fever; allergy can also cause vomiting and rashes.

If the reaction is restricted to the part of the body in contact with the allergic-causing substance, the reaction is termed a local allergic reaction. Examples might be asthma from inhaled house dust mite or conjunctivitis from grass pollen landing in the eye.

If the allergy causes effects remote from the site of contact, such as asthma from a wasp sting or urticaria from eating an egg, the reaction is generalised. Severe generalised reactions may cause many symptoms, such as wheezing, urticaria, vomiting and conjunctivitis.

Anaphylactic reactions are acute, severe, generalised reactions that are life threatening either because of breathing difficulty or shock. Anaphylaxis is often used as another word for an anaphylactic reaction, but it should properly be reserved for the extreme form of allergy that can result in an anaphylactic reaction.

Anaphylaxis or allergy?

There is no generally agreed definition of anaphylaxis. One difficulty is that even hay fever could be thought of as anaphylaxis because an injection of grass pollen will cause an anaphylactic reaction in someone with severe hay fever. Normally, only microscopic quantities of grass pollen are inhaled, causing rhinitis and conjunctivitis: an anaphylactic reaction is only a possibility if there is an accidental overdose from a de-sensitising injection containing too large a dose of grass pollen extract.

Another difficulty is that anaphylaxis is commonly unrecognised. If a man is stung by a wasp, he may pass through a phase of being allergic to wasp venom 4–12 weeks after the sting. Unless he is stung again in this sensitive interval he will never know that he has been at risk of a reaction. If he is stung and suffers a severe generalised allergic reaction, he clearly had anaphylaxis at the time of this second sting.

Sometimes anaphylaxis needs another factor as well as contact with the allergen. Exercise-induced, food-related anaphylaxis is well recognised. In this condition, if the allergen is an apple, then individuals with this form of anaphylaxis will have positive allergy tests for apple but will only react if they eat the apple and then take vigorous exercise.

Mechanism of anaphylactic reactions

Anaphylaxis is due to highly active IgE antibodies to the substance that triggers the reaction. These antibodies may be formed as an immune response to the first contact with the 'allergen' – the substance that causes the allergy.

These allergic antibodies are held on the surface of mast cells. These cells occur throughout the body but are particularly common at sites where contact with allergens may occur, such as in the skin, gut and lungs. When someone with anaphylaxis is exposed to enough of the allergen, the mast cells are triggered to release histamine and secrete other inflammatory mediators such as prostaglandins (PGD2) and leukotrienes (LTC4). Together these agents cause

Continued on PII ▶

◀ Continued from PI

the reaction, which varies from one person to the next (table 1).

Causes

Nut allergy

This allergy is very common: one in 80 young children have positive tests for nut allergy, and one in 300 children have had such a severe allergic reaction that they have been taken for emergency medical help. Deaths from nut allergy are rare: about four have been recorded each year for the last few years and none were in children under 12 years old.

Drugs

Anaphylaxis is commonest to natural substances but is well known to drugs such as penicillin. Reading the medical literature one would think that penicillin allergy was the commonest form of anaphylaxis.

Muscle relaxants used at induction of anaesthesia top the list of fatal reactions to drugs and radiological contrast media are still associated with fatal reactions, though these are less common since the introduction of non-ionic media. Only one fatal reaction ascribed to benzylpenicillin has been reported in the last five years in the UK.

Though severe generalised reactions are more common to foods and stings, death from drug anaphylaxis is as common as death from food or venom anaphylaxis. This may be because drugs are commonly injected, and even a low degree of sensitivity may result in a severe reaction because of the high dose compared with, say, a wasp sting.

Other causes

Anaphylactic reactions have many different causes (figure 1). Exposure to the cause may be by inhalation, ingestion, injection or even skin contact. A new pair of latex gloves may carry enough rubber tree sap protein on the surface to cause an anaphylactic reaction when a person with latex anaphylaxis puts them on. Wasp or bee stings are a natural form of injection, and venoms seem to have a strong tendency to promote an allergic response in people who have no other allergy.

Nut allergy, on the other hand, is most common in atopic children. Atopic means they have an innate tendency to allergy, and may have eczema, asthma or hay fever as well as nut allergy.

Twenty per cent of anaphylactic reactions are 'idiopathic', in that there seems to be no external cause that could have caused them.

Pathophysiology

Because someone must have allergic antibodies before they can have an allergic reaction, the first contact with the allergen cannot cause a reaction. This has led to much speculation about how children with nut allergy become sensitised when they react to their first contact with a nut.

Peanut oil (arachis oil) in creams applied for sore nipples while breast-feeding has been blamed, but this seems unlikely as the oil contains so little protein that it could not realistically sensitise the breast-fed infant; it is more likely to be nuts eaten by the mother late in pregnancy or while nursing her infant.

Recognition

You might be forgiven for thinking that anaphylactic reactions are so dramatic that they would be easy to recognise. This is not the case. They are often confused with panic attacks (which may cause sudden difficulty breathing, table 2) or with shock from vasovagal reactions (table 3). This confusion is aggravated by the panic that commonly accompanies anaphylactic reactions.

Assessing risk

If reactions are unpredictable, how should the risk of a future life-threatening reaction be assessed? In the case of severe allergy to white fish, one would think it possible to avoid eating this food. Recently an unfortunate woman with fish allergy was in a restaurant and when the waiter walked past her table with a sizzling fish dish, the steam was enough to cause her to have a fatal attack of asthma. Fish allergy generally carries a low risk of re-exposure once the allergy is recognised.

Peanut allergy, on the other hand, carries a high risk. Sensitivity may be so severe that minute traces of peanut may cause a severe, even life-threatening, reaction. Traces of peanuts may contaminate so many foods that even conscientious avoidance may be frustrated by an unexpected flake of nut in a cake or pie.

Treating reactions

Allergic reactions cause different symptoms in different patients. Some symptoms may have specific treatment, such as beta-2 adrenergic agonists for asthma; some are probably best untreated, such as vomiting from acute gastrointestinal allergy; and some, such as urticaria, may benefit from antihistamines. Steroids are often given, but acute allergic reactions have generally past long before the steroid would have any beneficial effect.

Adrenaline

There is general agreement that anaphylactic reactions should be treated with adrenaline. This assumes that it is possible to recognise that the reaction is anaphylactic rather than some lesser degree of allergy.

It is thought that the earlier adrenaline is given, the greater its chance of preventing the reaction becoming severe. This has led some doctors to recommend to their patients that they carry adrenaline and inject it at the first sign of an allergic reaction.

On the other hand, if a patient has had specialist advice about their food allergy, future reactions are most commonly minor and would recover quickly without treatment. If their reaction was to a wasp sting, the chance of a lesser reaction to the next sting has been calculated as 40-75 per cent in different studies. If the last sting produced a severe reaction, it is likely to be a good idea to inject adrenaline early if there is no contraindication.

Contraindications

Though adrenaline is probably the best treatment for a genuine anaphylactic reaction, there may be specific contraindications or cautions for its use. Patients with ongoing panic attacks may already have raised levels of adrenaline in the circulation and increased sympathetic tone. Additional adrenaline could cause a dangerous increase in blood pressure, particularly in an older person.

Intravenous adrenaline is

Continued on PIV ▶

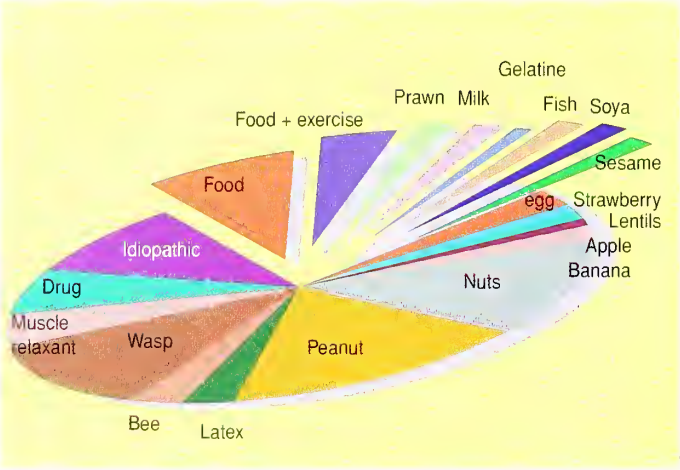


Figure 1. Causes of anaphylactic reactions in patients seen in the author's clinic. Those labelled 'food?' were most probably idiopathic reactions

Table 1

Receptors on	Pharmacological action	Clinical effect
Vascular smooth muscle	Relax	Central hypotension, increased capillary pressure
Vascular endothelial cells	Contract leading to increased permeability	Leakage, angioedema, urticaria
Bronchial smooth muscle	Contract	Bronchospasm
Mucus glands	Secrete	Congestion, mucus plugging of bronchi, rhinorrhoea

Histamine, prostaglandin D2, leukotriene C4 and bradykinin cause similar effects through different pathways. Adrenaline reverses many of these effects

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◀ Continued from PII

particularly hazardous, and should never be used in a conscious patient. Intravenous adrenaline given as a bolus has been associated with fatal arrhythmia, prolonged unconsciousness, severe headache and intracerebral haemorrhage.

Adrenaline is more likely to cause arrhythmia in patients on tricyclic antidepressants, probably because they inhibit noradrenaline reuptake and so potentiate the effect of adrenaline.

Self-treatment

Adrenaline is the only drug that will act fast enough to rescue someone from a life-threatening reaction.

Injected adrenaline should be intramuscular for reliable absorption. Devices such as the Min-I-Jet have proved too difficult for the patient to cope with in an emergency, as they need to be assembled and the dose adjusted before use. The short shelf life is another problem for devices that may never be used but the patient may need to carry for years.

Popular autoinjectors include the EpiPen and Anapen, both giving 0.3 mls of 1:1,000 adrenaline for adults and children over 30kg, and 1:2,000 adrenaline for children 15-30 kg. Both these have trainer pens, and clinical experience has shown that it is important for patients to rehearse the use of the pens regularly. Unlike diabetics who have to inject themselves on a daily basis, anaphylactics may never use their pen and quickly forget how to use it unless they check the procedure from time to time. Another reason for trainer pens is that anaphylactics who may lose consciousness rapidly during a reaction should train a friend who will be able to use the pen if needed.

Table 2. Panic or anaphylactic reaction following suspected exposure to an allergen?

Panic	*Anaphylaxis*
palpitations	palpitations
dizzy, faint, altered sensations (hypocapnia)	dizzy, faint, altered sensations (hypotension)
sense of impending doom	sense of impending doom
hyperventilation (may be stridor or phonation due to paradoxical vocal chord movement)	bronchospasm (polyphonic wheeze)
sensation of choking	pharyngeal oedema (may be visible)
paraesthesiae	pruritus (may be paraesthesiae of lips)
no conjunctivitis	conjunctivitis common

Table 3. Vasovagal or anaphylactic reaction following an injection?

Vasovagal	*Anaphylaxis*
hypotension	hypotension
faintness	faintness
loss of consciousness	loss of consciousness
pulse slow	pulse commonly rapid
skin pale	red or urticaria; but if severe hypotension, no urticaria, skin pale

Pen dispensing

Pharmacists could help ensure that these pens are appropriately dispensed by checking the following points:

- The shelf life of these pens is two years at manufacture, and patients will expect their pen to last two years. It will usually be better for the patient to wait a week for a new order, rather than be dispensed a pen which has only six months' life left.
- Check that the pen prescribed is the correct dose for the size of its user.
- Check if the patient is taking a tricyclic antidepressant or MAOI.
- Check that the patient has been trained in the use of the pen. If they have not been trained and given written instructions for coping with reactions, they should ask for referral to a specialist.
- The next point is one that needs delicate handling! If a patient is overweight, the subcutaneous fat may be thick enough to prevent the pen giving an intramuscular injection (the needle in the adult EpiPen is only 1.6cm long). If adrenaline is injected into the subcutaneous fat, its absorption will be unreliable.
- If the pen is for a schoolchild and pens have been prescribed for use at school, it is very important that the school is told about this by the Community Paediatric team, not by the parents of the child.

Other devices are available such as the AnaKit and Anaguard, and patients from the US will look for the Epi E-Z Pen if they need a replacement. This is smaller than the EpiPen and activated by pressing a button on top.

If a patient has used their pen, they should go to the nearest A&E unit to have the rest of the necessary treatment – antihistamine and steroid. The steroid is needed to prevent a second phase to the reaction, which may include further swellings (angioedema) or wheezing.

Accidents with pens have involved injection into fingers – or even toes! If this happens it may be necessary to inject an alpha-adrenergic receptor antagonist to reverse the arterial spasm that may threaten the viability of the injected digit. The dose is phentolamine 1 mg/ml, 1-1.5 mls for the adult pen and 0.5-0.7 mls for the junior, infiltrated at the site of the accidental injection.

Is there a cure?

It has long been known that patients with severe allergy can be de-sensitised to the allergen that causes their reactions by injecting gradually increasing dose of the allergen. This reduces the chance of a severe reaction, but does not eliminate it altogether. This technique is still used for patients with bee or wasp anaphylaxis, but has proved too hazardous for patients suffering from nut allergy. New developments focus around peptide vaccines in the hope that these might be effective without the danger of provoking an anaphylactic reaction during treatment. Another approach has been to try to alter the function of the high affinity IgE receptor on mast cells, preventing their activation in the presence of the allergen. This approach involves immunising the patient with a peptide derived from the structure of IgE where it binds to the receptor. Trials of this therapy have had encouraging preliminary results.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning material until October 2000.*

Note

The only available inhaled adrenaline (Medihaler-Epi) has recently been withdrawn by 3M Health Care.

Anaphylactoid reactions

Anaphylactoid reactions are similar to anaphylactic reactions but the mast cell activation is independent of IgE antibodies. Not only do mast cells have other receptors that can trigger histamine release; they are also innervated by different types of autonomic nerve fibre leading to the possibility that they can be activated as part of a stress reaction of as the result of a conditioned reflex.

Other reactions with similar features may be due to activation of the contact system producing bradykinin, or idiosyncratic alterations in the icosanoid pathway leading to increased leukotriene secretion. Scombrotoxin poisoning too can lead to symptoms like an acute generalised allergic reaction; scombrotoxin is now known to be histamine which can accumulate at high levels in certain foods, in particular scombroid fish such as mackerel or tuna

ACTION PLAN

1. Think about what you would tell a patient who asks what precautions to take to avoid a potentially anaphylactic agent (peanuts, wasps, shellfish). Record a protocol in your practice workbook
2. Check the source and availability of the various adrenaline pens
3. Carefully read and learn the method of use of each adrenaline injection device you dispense
4. Whenever you dispense an adrenaline pen, ensure the patient has been trained in its use

No.1 TUTORIAL

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THE COLLEGE OF PHARMACY PRACTICE

This tutorial has been designed to meet the requirement of the College of Pharmacy Practice in providing 1 hour of postgraduate education towards the College's continuing education requirement

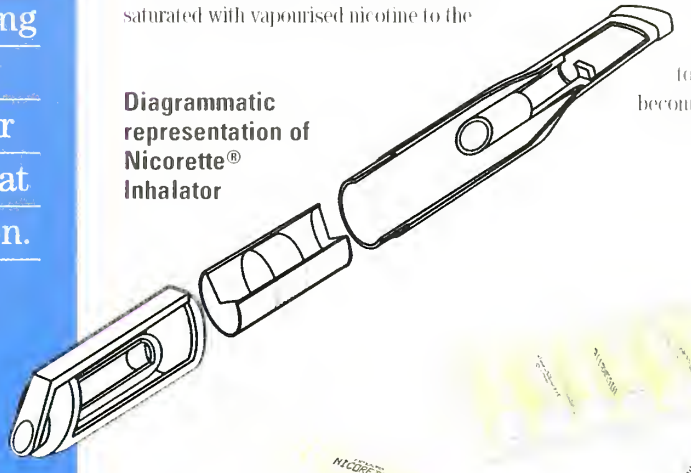
NICORETTE® *Inhalator*

Nicorette Inhalator is the only nicotine replacement therapy (NRT) which deals directly with physical as well as behavioural dependence in smokers. Nicotine is inhaled orally via a mouthpiece containing a plug impregnated with 10mg of the drug. Here, we look at how use of the Inhalator can get smokers across that vital first step to abstention.

In smokers, there are two principal routes of absorption of nicotine base; the buccal mucosa and the lungs. Nicotine base is strongly alkaline and has high solubility in both water and lipid media. The molecule is non-ionised at high pH, so for 'non-inhalers' absorption is primarily through the oral mucosa and is pH-dependent, while for 'inhalers' there is much greater absorption of nicotine through the small airways and alveoli of the lungs, where pH is not a limiting factor.

The Nicorette Inhalator introduces air saturated with vapourised nicotine to the upper respiratory tract. The nicotine is absorbed mainly through the buccal mucosa. The amount of nicotine released depends on the volume of air passing through the nicotine-impregnated plug (10mg), and the air temperature.

The Inhalator was specifically designed to address the behavioural and sensory stimulation offered by smoking, thus facilitating the first step to abstention. This is because its use mimics the hand to mouth activity and sensory stimulation of smoking, which together deliver the reward of nicotine to real smokers, which in turn becomes highly reinforced behaviour.



Diagrammatic representation of Nicorette® Inhalator

The Nicorette Inhalator mouthpiece, with sealed cartridges containing the nicotine-impregnated plugs

OBJECTIVES

To understand:

- how nicotine is absorbed through inhalation
- how the inhalator works and its use as a nicotine reduction therapy
- key advice and guidance for users

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NICORETTE® *Inhalator*

Nicotine dependence

Nicotine dependence is a combination of both behavioural and pharmacological factors, with pharmacological dependence probably dominant. Following inhalation of a cigarette, nicotine is absorbed through the lungs and high concentrations reach the brain in seconds. This rapid effect may be an important factor in nicotine dependence. Smokers experience mood changes, including pleasure, arousal and improved concentration.

The Nicorette Inhalator does not provide the high nicotine peaks achieved in smoking, delivering levels approximately one-third of those reached by cigarette smoking. This level is adequate to suppress the symptoms of nicotine craving and withdrawal. As such, the Inhalator offers: behavioural replacement; a flexible dosage regime allowing ad libitum administration of nicotine; a few, mild adverse reactions; reduction of the barriers to giving up smoking.

The device is appropriate for those who smoke 20 or less cigarettes a day and/or are highly behavioural-dependent.

While the physically addictive nature of nicotine follows a classical cycle, the continual reinforcement of smoking in social situations is common. Peer pressure among the young is considerable, where the perceived need is to appear sophisticated or older. Certain situations can trigger smoking – for example, stressful times, social drinking or meal-taking. The Nicorette Inhalator is the form of NRT that can deal with such behavioural dependency.

Technique and temperature

The bioavailability of inhaled nicotine from the device has been examined via two criteria: the effect of temperature on the release of nicotine from the cartridge; and inhalation technique.

As it is likely that the Inhalator will be exposed to a range of ambient temperatures during daily use, the effect of the environmental temperatures (20°, 30° and 40°C) on nicotine release was investigated and plasma concentrations determined. The product was found to work best at room temperature. Below 15°C, nicotine evaporates more slowly and it is therefore necessary to inhale more frequently.

The influence of inhalation technique using the device was compared with normal cigarette smoking and the plasma levels of nicotine achieved in both cases. Technique (pulmonary or buccal mode) does not affect nicotine deposition. Also, the bioavailability of nicotine following deep inhalation (56 per cent) versus shallow sucking (51 per cent) modes of inhalation was comparable.

Clinical efficacy

Clinical efficacy was rated in terms of three predefined criteria in six double-blind, randomised placebo-controlled studies: abstinence for at least one month after week two; abstinence at all sessions from week two onwards with relapse allowed; complete abstinence from day one onwards.

In total, 1,440 healthy smoking volunteers [1] (mean age 43.8 years) were studied in Denmark, the United States and Sweden between 1990 and 1993. The results of the Danish study are set out in Figure 1 and are statistically significant at all time points measured

In the Danish study of 286 volunteers [2], the inhalation device was used regularly for three months and then its use was tapered off for a period of three months. The abstinence rates with the nicotine inhalation device were significantly higher than those of the placebo : 37 per cent compared to 19 per cent at six weeks follow-up, 25 per cent compared to 13 per cent at three months, 19 per cent compared to 10 per cent at six months and 17 per cent compared to 6 per cent at 12 months.

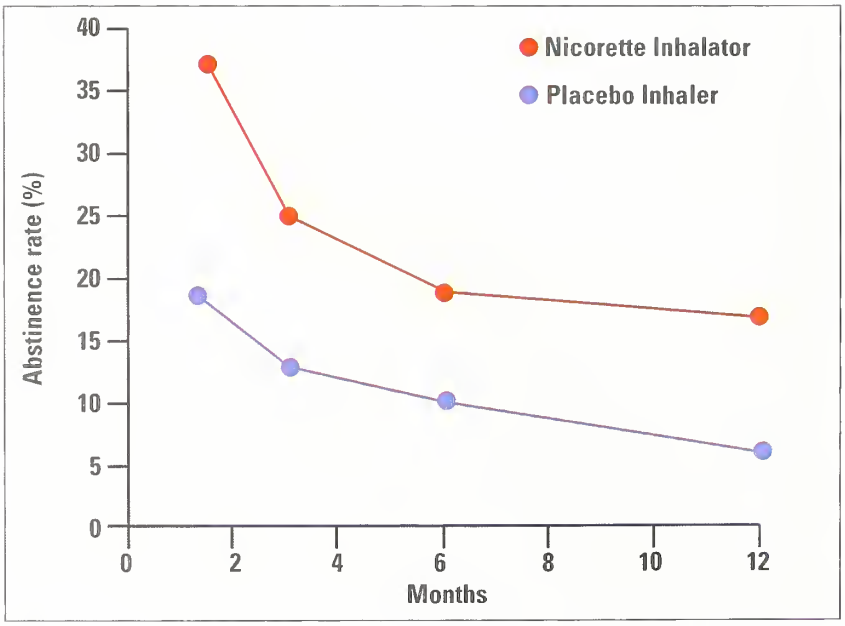

FIGURE 1: A comparison of the abstinence rates (from week 2) achieved at various time points over a 12-month timespan in volunteers using either a nicotine inhaler or placebo inhaler

Effects on craving

Craving for nicotine is believed to play an important role in maintaining dependence and causing relapse, even though physiological withdrawal may be complete. There is a strong correlation between plasma nicotine concentration and craving. Thus, the efficacy of Nicorette Inhalator in satisfying the craving aspects of nicotine addiction is very important for preventing relapse.

In a clinical study of 223 subjects [3], satisfaction and preference for the nicotine inhalation device were significantly greater than for the placebo . The sensory effects of taste and smell from it were also rated more highly than the placebo.

Pharmacy advice

If a customer wants to stop smoking by using an NRT device, first check whether or not they are pregnant or are breastfeeding, or if they are taking any other medication.

Whether or not NRT is used, stopping smoking may alter the pharmacokinetics of several drugs and require dose adjustment. Drugs which may be affected include caffeine, imipramine, insulin, paracetamol, pentazocine, propanolol, oxazepam and theophylline.

Explain to the customer that if they use any NRT device they should not smoke at all. Of course, all forms of NRT are contra-indicated for the under-18s (Nicorette Nasal Spray-16 yrs & under). Then determine if NRT is suitable for them and whether the Nicorette

The high level of clinical acceptance of Nicorette Inhalator should encourage good compliance and thus lead to greater suppression of withdrawal effects

Inhalator is the form for them.

Pharmacists are well placed to present the health benefits of not smoking and to develop an appropriate smoking cessation programme for an individual patient. Follow-up procedures can be arranged. By obtaining a smoking history, nicotine dependence and the success of previous 'quit attempts' can be gauged.

If the smoker is highly behavioural-dependent and smokes no more than 20 cigarettes a day, then the Nicorette Inhalator may be the appropriate form of NRT. Before recommending any form of NRT pharmacists should explain:

- the role of nicotine in tobacco smoking, particularly the reasons why nicotine dependence makes it difficult to quit
- the rationale of NRT in smoking cessation
- nicotine withdrawal symptoms and how these can be overcome, both pharmacologically and physiologically.

The Nicorette Inhalator mimics the hand to mouth activity and sensory stimulation of smoking which delivers such a reward to smokers

Technique

Explain that the user can inhale Nicorette's nicotine vapour by shallow puffing, or by deeply inhaling. The amount of nicotine absorbed is the same whichever technique is used and happens when air is drawn through the mouthpiece by sucking.

The Inhalator works best at room temperature (15-20°C or 50-68°F). If it is used when the ambient temperature is below 15°C, the Inhalator must be sucked more frequently to get the usual effect as the nicotine will evaporate more slowly.

Dosage

Each loaded mouthpiece is charged with 10mg of nicotine. This dose will last for approximately 20 minutes if used continuously, during which period it will give up around half of the drug. However, this supply is not meant to be used all at once. It should be recommended to the patient that use of the Inhalator be divided into sessions of, for example, two by ten minutes; four by five minutes; or ten by two minutes. Of course, individuals may vary the number, frequency and duration of inhalations, according to their personal preference.

It is recommended that patients use six to 12 cartridges a day to provide adequate nicotine replacement and to depress withdrawal symptoms. The chances of success of the cessation programme are increased by correct and regular use of the device.

For the first eight weeks it is recommended that no less than six and no more than 12 cartridges are used, with the number per day decreased gradually to half that dose through weeks nine and ten. Then, over weeks 11 and 12, the patient should gradually wean themselves off the device totally.

Using the Inhalator

Assembly and cleaning should be explained thus:

1 Peel back foil as shown on label and remove cartridge from the tray.

2 Separate the two parts of the mouthpiece.

3 Insert the sealed cartridge – the tube containing one of the nicotine-impregnated plugs – into the mouthpiece.

4 Re-assemble the mouthpiece, thus breaking the seal on both ends of the cartridge.

5 The Inhalator is now ready for use.

6 The empty mouthpiece should be cleaned by rinsing in water several times a week.
It can be reused with new cartridges.

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NICORETTE Inhalator

The Nicorette Inhalator, loaded and ready for action

Side-effects

Side-effects occur most frequently during the early stages of treatment and decrease with repeated use of the device. Typical symptoms are usually mild. Included among them may be cough, hiccups, irritation in the mouth, sinusitis and sore throat. Other systemic effects may include headache, heartburn and nausea.

Contra-indications

Nicorette Inhalator is not suitable for patients who are allergic to nicotine, menthol or those who have severe respiratory incapacity. Patients who are pregnant or breastfeeding should not smoke nor use NRT, as nicotine is carried to the baby in the blood and the mother's milk.

The device should be used with caution in patients with the following conditions, who should be advised to consult their doctor before use:

- Diabetes mellitus
- Cardiac arrhythmias (severe)
- Gastritis
- Hepatic impairment
- Hypertension
- Hyperthyroidism
- Myocardial infarction (recent)
- Peptic ulceration
- Peripheral vascular disease.
- Phaechromocytoma

Reduction therapy

Long-term use of any NRT device is not recommended. Equally, this applies to Nicorette Inhalators, which should be used as a temporary relief until the psycho-social factor of dependence has been reduced.

Best practice guidelines

For optimal use of the Nicorette Inhalator explain:

- **its objectives and demonstrate its best use**
- **the importance of adequate nicotine substitution to avoid the possible onset of withdrawal symptoms**
- **that local adverse reactions are commonplace and will decline with use**
- **that the dosage regime is flexible and should be reduced over the final six to eight weeks**
- **that it is not easy to give up smoking and that the patient must be highly motivated for the programme to succeed**
- **that used cartridges contain nicotine and so must be returned to the foil tray after use for disposal in household rubbish.**

References
1 Monograph Pharmacia & Upjohn Figure 8 Data on file
2 Tonnesen P, Norregaard J, Mikkelsen K, et al A double-blind trial of a nicotine inhaler for smoking cessation JAMA 1993, 269 1268-71
3 Schneider et al Addiction 1996, 91(9) 1293-1306

Note Clinical papers and Inhalator Monographs can be obtained by calling the Medical Information Department, Pharmacia & Upjohn, Davy Avenue, Knowlhill, Milton Keynes MK5 8PH Tel 01908 661101

Abbreviated Prescribing Information

Presentation: Inhalation Cartridge containing 10mg nicotine for oromucosal use via a mouthpiece **Indications:** Nicotine dependence and symptom relief in smoking cessation **Dosage:** Adults and Elderly – Weeks 1-8, 6-12 cartridges /day Weeks 9-10, half number of cartridges Weeks 11-12, stop usage Children – contra-indicated below age 18 years **Contra-indications:** Intolerance to menthol or nicotine Pregnancy and Lactation Non-tobacco users **Special Warnings:** Cease smoking before use Best used at room temperature **Caution:** In peptic ulcer, recent myocardial infarction, arrhythmias, hypertension, peripheral vascular disease, gastritis, renal or hepatic disease, diabetes, hyperthyroidism, phaeochromocytoma. **Interactions:** Dose of some drugs may need adjusting – see leaflet **Side-Effects:** Most commonly cough, irritation of nose, mouth and throat, gastro-intestinal symptoms **Pharmaceutical Precautions:** Store below 30ºC **Legal Category:** P **Package Quantities and Cost:** 6 – Starter Pack – £5 95 42 – Refill Pack – £19 95 **PL Holder:** Pharmacia Laboratories Ltd, Davy Avenue, MILTON KEYNES MK5 8PH Tel 01908 661101 **PL Number:** PL0022/0163 **Date of Preparation:** November, 1997 **Disposal Instructions:** Used cartridges still contain nicotine and are thus hazardous Return to foil tray and dispose of in household rubbish

Testing your understanding

This tutorial, together with the following questions, provides one hour of continuing education. Test your understanding by answering these questions, then check your answers by phoning our computerised Telephone Marking Service on **0990 27 44 25** for an immediate result. Just listen to the instructions and press buttons 1 or 0 to indicate your answers. '1' indicates true; '0' indicates false.

College of Pharmacy Practice members or pharmacists reaching the the required 70 per cent standard and requiring a Certificate of Completion should send a signed photocopy of this completed questionnaire to: Sue Cheeseman, Pharmacy Group Special Projects, Miller Freeman plc, Sovereign Way, Tonbridge, Kent TN9 1RW. (Please note that calls are charged at standard national call rates only.) Assistants who reach the same standard should do likewise. They will be sent *Chemist & Druggist*/Pharmacia & Upjohn certification.

Please enter below your name and status (eg 'pharmacist', stating RPSGB/PSNI number, or 'assistant'), pharmacy, address, phone number:

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1 The strongly acidic nicotine base is highly soluble in both water and lipid media

☐ Yes ☐ No

2 The Inhalator is designed to address the behavioural and sensory stimulation offered by smoking

☐ Yes ☐ No

3 The device delivers approximately half the nicotine levels achieved by smoking

☐ Yes ☐ No

4 The Inhalator is appropriate for behavioural-dependent smokers using 30 or less cigarettes daily.

☐ Yes ☐ No

5 Smoking technique using the device (pulmonary or buccal) affects nicotine deposition.

☐ Yes ☐ No

6 The device delivers the best results when used in hotter climates as more nicotine vapourises on inhalation.

☐ Yes ☐ No

7 Deep rather than shallow inhalation produces greater nicotine absorption for Inhalator users.

☐ Yes ☐ No

8 Half the Inhalator's 10mg charge of nicotine can be absorbed over 20 minutes of split usage.

☐ Yes ☐ No

9 Over the first eight weeks of use no less than six and no more than 12 Inhalators should be used daily.

☐ Yes ☐ No

10 The device is contra-indicated in severe cardiac arrhythmias and recent myocardial infarctions.

☐ Yes ☐ No

Ear problems

Derek Balon, community pharmacist and King's College lecturer, reports on ear disorders

Disorders of the ear are common and are usually presented to pharmacists as either earache or wax causing discomfort or loss of hearing. Both presentations require careful analysis to establish whether the patient may be treated by the pharmacist or should be referred to their GP.

Incidence

A PAGB survey shows that up to 14 per cent of adults reported ear problems in a 12 month period. This figure is higher than many pharmacists experience, and suggests that many of these patients present to the doctor, or the condition is self limiting.

Excess wax

The epidermis of the external auditory canal has hairs which, together with cerumen, act as a trap for foreign particles. Cerumen is derived from secretions of two types of glands (sebaceous and apocrine) sited in the external auditory canal.

The apocrine glands secrete a watery fluid which combines with the oily secretion of the sebaceous gland to form cerumen. This combines with exfoliating cells from the *stratum corneum* and foreign particles to form a waxy material commonly called earwax. Among the components of cerumen are fats, fatty acids, carbohydrates, proteins and water.

In normal circumstances, semisolid cerumen is expelled by the migration of epithelial cells from deep within the ear to the outside. This is facilitated by normal mouth movement. The area has a pH of between 5.2 and 7.0 which discourages growth of pathogens.

Pathophysiology

Excess ear wax may be the result of three events: 1) the physical structure of the external auditory canal; 2) either excess cerumen production or abnormal secretions (softer or drier); or 3) impaction due to repeated attempts to remove it with a cotton bud.

When swimming, shampooing or bathing, water may become trapped behind the wax and this may result in unusual sensation and hearing loss.

Patient presentation

Patients present in many ways depending on the cause of their discomfort. Some comment on water in the ear following swimming or a shower, some complain of deafness or reduced hearing and some experience pain.

It is important to establish that the patient really is in pain and not just discomfort. The presence of severe pain requires referral in all cases.

Questions to ask:

- Do you have an earache or any pain in the ear?
- How long have you had the problem?
- Have you any loss of hearing?
- Is there any discharge?
- Do you hear ringing or are you dizzy?
- Have you been swimming/flying recently?

Diagnosis

As this section is only concerned with excess wax in the ear, we are only looking at the major features of this condition. Nearly all cases of pain require referral.

- **Symptom complex/region**

The most common symptom is some loss of hearing together with a sensation that the ear is blocked (a feeling of 'fullness'). Pain must be absent for the pharmacist to treat: the presence of pain requires referral.

- **Region**

The sensation must be restricted to the outer ear canal. If pain is experienced behind the ear, which indicates infection, referral is required. Impacted cerumen is usually unilateral, although if over enthusiastic cleaning of the outer ear has been practised, bilateral involvement will occur.

- **Universal factors**

Some patients produce an excessive quantity of cerumen. Comments such as, 'the patient often requires to have their ears syringed', provide clues to this problem.

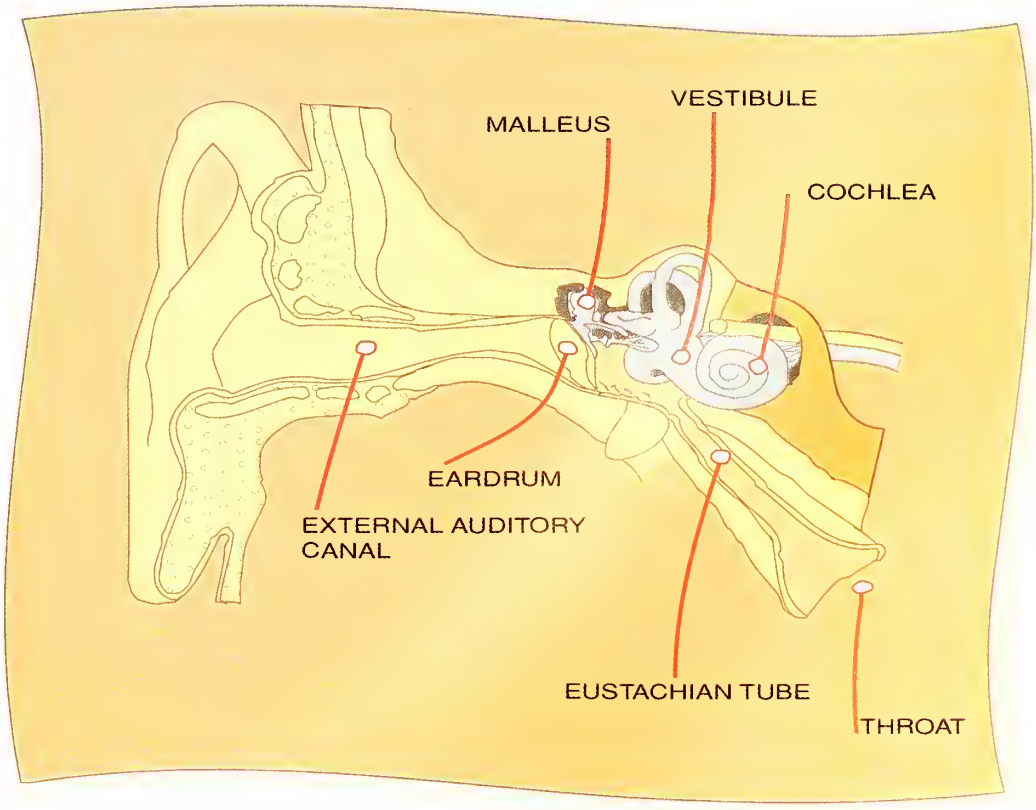
Continued on PVI ▶

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1075), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JANUARY 10, PROVIDES ONE HOUR'S CONTINUOUS EDUCATION

OBJECTIVES

- To be aware of the common presentations of ear disorders
- To recognise when to treat and when to refer to the GP
- To recognise the features of excess wax in the ear
- To understand the mode of action of wax removing agents
- To be able to diagnose and manage problems related to eustachian tube blockage



The eustachian tube connects the inner ear with the nasopharynx and normally allows pressure equalisation between either side of the tympanic membrane

Continued from PV

Provoking factors: Use of cotton buds may result in wax impaction. Excessive wax will also trap water from any source such as swimming, showering and shampooing the hair.

Relieving factors: There are few relieving factors for ear wax.

- **Time/Intensity**

Temporary loss of hearing may result from water in the external ear canal but this usually resolves itself a few minutes after ceasing to be exposed to water. Patients reporting an intermittent temporary loss of hearing suggest that the problem is trapped water.

Another feature of excess cerumen is that the problem of hearing loss increases with time. However, remember that more serious conditions (otosclerosis, auditory nerve damage) may also have a similar picture.

- **Natural history**

Progressive hearing loss and the feeling of a blocked ear are insidious features and provoking factors may provide valuable clues to the cause of these symptoms.

- **Your current medication**

This is rarely pertinent, but it is important to remember that some drugs are ototoxic (aminoglycosides).

Management

Management is simple: use of a solvent to remove the excess cerumen. If simple solvent/softening treatment fails, the patient should be referred.

- **Chronic/risk group/age**

Cerumen build up is common in the elderly, but caution should be exercised that the hearing loss is not due to auditory nerve loss. This potential problem should be checked by a doctor. Young children should not be affected. They should be referred. In infants, the use of cotton buds may be the cause of excess impacted cerumen. Referral is essential.

- **Allergies**

There are many reports of allergies to earwax removal agents and caution should be exercised when recommending a product to see if the patient has had any previous experience of it.

- **Reaction of proposed medication**

The warning above applies to reactions to proposed medication.

- **Establish patient preference** All treatments involve placing drops in the ears so there is little patient choice.

Cerumen build up in the elderly should be checked by a doctor

Product selection

Local anaesthetics are no longer included in OTC preparations to treat ear problems. Analgesics should not be used for any ear problem without prior medical consultation. They are not indicated for cerumol impaction, as pain will not be present. If pain is present, their use may provide the patient with relief. However, they may result in the patient not consulting a doctor before permanent damage occurs from more a serious condition.

There are four types of wax removing agents:

- those based on oil
- those using surface active agents
- those using 'bubbles'
- urea and glycerol.

Oil based: cerumen has hydrophobic components which makes it soluble in, or at least softened by, oil.

Surface active agents: these increase penetration of cerumen by water and thus soften the impacted mass.

Bubbles: the use of hydrogen peroxide and sodium bicarbonate ear preparations rely on the idea that the gas released in the ear gives a mechanical means of removing the wax. Sodium bicarbonate releases carbon dioxide by reaction with the acidic materials in the ear (pH of the ear is below 7).

Urea and glycerol: these probably act by increasing hydration of cerumen.

There is little compelling evidence to favour any of these different agents, nor is there any to favour commercial preparations containing more than one active agent.

All wax removing agents should be used for three to five days. The head should be bent towards the opposite side of instillation and the drops instilled (five drops twice a day). This position should be retained for about five minutes and then the opposite ear treated. Ear plugs are not needed. If the wax does not clear spontaneously, it is advisable to make an appointment with a doctor to syringe the ear.

Eustachian problems

The eustachian tube connects the inner ear with the nasopharynx and normally allows pressure equalisation between either side of the tympanic membrane. If this tube is blocked, oxygen in the air trapped between the tympanic membrane and the pharynx is absorbed, resulting in decreased pressure in that region. This causes the tympanic membrane to be distended with loss of hearing and often pain.

Blockage may result from an upper respiratory infection (coryza), allergic rhinitis or middle or inner ear infection. Another cause of temporary hearing loss is due to a sudden change in pressure (barotrauma/barotitis media) from flying or even travel by train into a tunnel at speed.

Swallowing may temporarily reduce or remove the blockage, equalising the pressure. This often resolves barotrauma and may help in the case of eustachian tube catarrh.

Another technique is to increase nasopharyngeal pressure by closing the nostrils and pressurising the mouth (from the lungs). This involves some danger of creating too much pressure and damaging the eardrum (tympanic membrane). To avoid this, there is a device available (Otovent) which controls the maximum pressure.

Diagnosis

Eustachian tube catarrh may be diagnosed by consideration of the symptoms which are similar to those of excess cerumen, together with the provoking factors such as a cold or hay fever. Relieving factors include swallowing and chewing movements. Barotrauma is related to sudden changes in pressure which are self-evident during patient interview.

Management

Management of eustachian tube catarrh relies on nasal and systemic decongestants which are discussed in the article on coughs and colds (*C&D* October 5; November 2). If any pain is present, caution should be exercised in recommending treatment. If treatment fails to relieve the condition in three days or the pain becomes continuous, referral is advisable. Continuous pain, especially without hearing loss, suggests infection which must be referred immediately. Remember that the inner ear is only separated from the cranial cavity by a thin membrane. Infection can and does pass this membrane relatively readily and thus serious complications can arise.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning material until October 2000.*

ACTION PLAN

1. Record in your practice workbook ten cases of ear problems in summer and ten in winter. Of the minor problems which you diagnose, note those which are cerumen related and those which are eustachian tube related. Is there a season-related pattern?
2. Develop a protocol for your pharmacy assistant to deal with patients presenting with temporary loss of, or reduction in, hearing. Include the points at which they should refer the patient to you.
3. In your practice workbook, list the recommended preparations for both conditions in order of preference. Make sure your pharmacy counter assistant is familiar with this list

PSORIASIS *movers*

- **Doctors like Dovonex.** ***As Ointment or Cream, the most prescribed psoriasis treatment in the UK.***[1]
- **Patients like Dovonex.** ***Clean and easy to use, it's not linked to the long-term fears of potent topical corticosteroids.***
- **You'll like the way they keep coming back for more.**

Prescribing information for Dovonex Cream/Dovonex Ointment and Dovonex Scalp Solution. Presentation: Dovonex Cream contains 50 micrograms calcipotriol per g (as the hydrate) Dovonex Ointment contains 50 micrograms calcipotriol per g. Dovonex Scalp Solution contains 50 micrograms calcipotriol per ml. Indications: Cream/Ointment: Treatment of mild to moderate plaque psoriasis affecting up to 30% of skin area. Scalp Solution: Topical treatment of scalp psoriasis. Dosage and Administration: Apply twice daily to the affected areas. Maximum weekly dose should not exceed 100g of Cream or Ointment or 60ml Scalp Solution. Not recommended in children or pregnancy as there is no experience of use. When Dovonex Scalp Solution is used together with Dovonex Cream or Ointment, the total dose of calcipotriol should not exceed 5mg in any week, e.g. 60ml Scalp Solution plus one 30g tube of Cream or Ointment, or 30ml Scalp Solution plus 60g (two 30g tubes) of Cream or Ointment. Contra-indications: Patients with known calcium metabolism disorders. Hypersensitivity to any constituents. Precautions: Should not be used on the face. Wash hands after application. Avoid inadvertent transfer to other body areas, especially the face. Hypercalcaemia has been reported in generalised pustular and erythrodermic exfoliative psoriasis. Use no more than maximum weekly dose since hypercalcaemia, which rapidly reverses on cessation of treatment, may occur. Drug Interactions: No interaction between calcipotriol and UV light. No experience of concomitant therapy with other antipsoriatic products applied to the same area. Side Effects: Cream/Ointment: Transient local irritation and facial or perioral dermatitis may occur. Other local reactions may occur. Reactions reported with Dovonex Ointment include dermatitis, pruritus, erythema, aggravation of psoriasis, photosensitivity and rarely hypercalcaemia or hypercalciuria. Scalp Solution as above. In addition, local irritation of the scalp or face may occur. Use during pregnancy and lactation: Safety for use during human pregnancy has not yet been established, although studies in experimental animals have not shown teratogenic effects. Avoid use in pregnancy unless there is no safer alternative. It is not known whether calcipotriol is excreted in breast milk. Overdose: Hypercalcaemia may occur in patients with plaque psoriasis who use more than [illegible] Ointment/Cream weekly, and has been reported at lower doses in patients with generalised pustular or erythrodermic exfoliative psoriasis. Basic N.H.S. Price: Dovonex Cream £8.15/30g, £16.30/60g, £29.40/120g. Dovonex Ointment £8.15/30g, £16.30/60g, £29.40/120g. Dovonex Scalp Solution £22.28/60ml. Legal Category: POM. Product Licence Holder/Numbers: Leo Laboratories Ltd. Dovonex Cream PL0043/0188, Dovonex Ointment PL 0043/0177, Dovonex Scalp Solution PL 0043/0190.

Further information [illegible]

LEO PHARMACEUTICALS [illegible]
Princes Risborough
Buckinghamshire [illegible]

References
1. IMS Medical Data Index [illegible]

Date of preparation: December [illegible]
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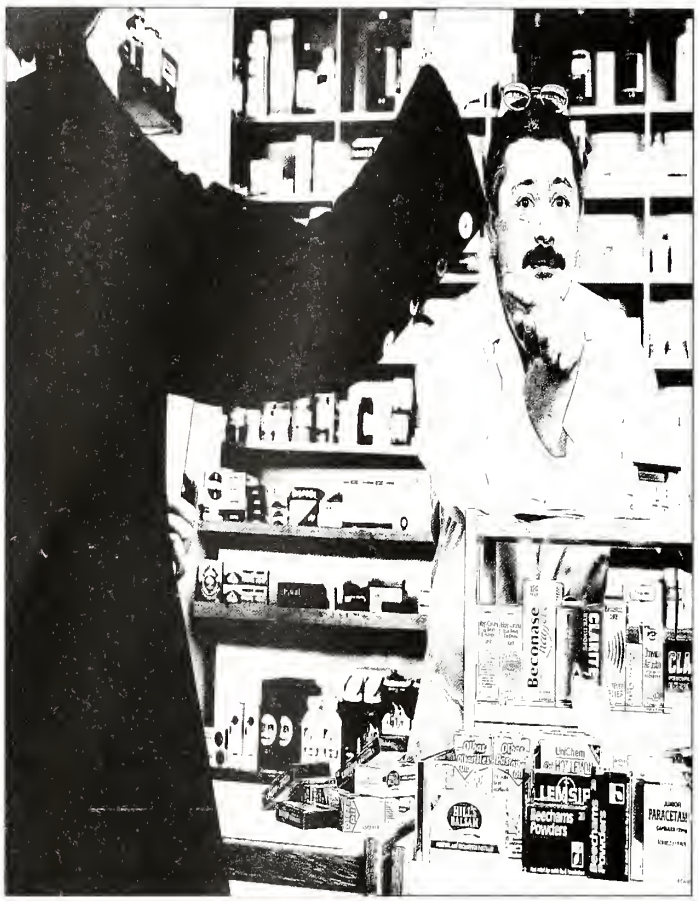
Dovonex®
calcipotriol

You'll like the way they like it

Fit to practice?

By Ruth Rodgers, independent pharmaceutical consultant and formerly of the Royal Pharmaceutical Society's law department



There is a duty on pharmacists, as professional people, to cope with the job

Ian has been pharmacy manager for Bloggs & Co for several years. Until recently, he had enjoyed his job, but then his regular locum left and the new locum was proving to be a problem.

Whenever Ian returned to work after a day off, he was greeted with a barrage of complaints from his staff about Mr Jones' work methods. Not only that, the dispensary always looked as if a bomb had hit it, with many incomplete prescriptions left for him to deal with. He had even been visited by two customers whose medication had been wrongly dispensed. That was enough! But what could he do?

Turning a blind eye

Ian knew that locum pharmacists were hard to come by in his area. He thought that if he were to complain to his boss he would only end up with the job of finding a replacement. To be honest, he had enough to do with the reasonable amount of dispensing and growing OTC sales advice without spending hours on the telephone.

The alternative would be to work through his day off and he didn't want to do that. So Ian decided that it was probably better to put up with Mr Jones until the locum situation became easier. He pacified his staff by explaining his situation and they agreed to try and help.

Each week, he returned to find matters deteriorating but kept telling himself that he needed to have his day off and that his boss would be unsympathetic to his problems. He could console himself that Mr Jones was working on the quietest day of the week, that he had the help of a trained dispenser and, after all, Ian needed his day off if he was to continue to function properly.

He also felt sorry for Mr Jones who had recently been made redundant from an industrial position after 20 years. Mr Jones seemed to be experiencing difficulties in coming to terms with the loss of his former position and would no doubt be worrying about his future career. Ian did not want to be the one to add to his difficulties.

Taking action

Ian phoned his boss. He said there was no way he could carry on with the new locum and could someone who was up to the job please be found. Ian's boss, Jim, was not happy to receive this news – it had been difficult to find a replacement locum in the first place – but he realised from Ian's tone that something had to be done. Jim asked Ian to leave the matter with him for a week or two.

The following week he visited the branch on Ian's day off with the intention of assessing Mr Jones at work. He had seemed very competent when booked for the position, but on the job he appeared flustered. Mr Jones would not let the rest of the staff get on with their work, and was interrupting every sale of OTC medicines to ask further questions. Jim knew the staff were all well trained, did not require such supervision and could be relied on to bring any concerns to the pharmacist in charge.

Mr Jones also flitted around the dispensary, he had at least six part-completed prescriptions on the bench, although there appeared to be no reason why they had not been completed. Jim could not understand the cause of the chaos. Ian coped very well with the demands of the business, the prescription numbers were lower than Bloggs & Co's average pharmacy at about 60 items a day, but the counter trade was exceptionally busy.

During a lull, Jim took Mr Jones to one side to ask how he felt he was coping with the demands of retail. Mr Jones' answer surprised Jim. He said he was really enjoying the buzz of a new environment. The challenge of dealing with customer requests was proving to be a satisfying aspect of the job that he hadn't anticipated. Mr Jones said he realised that he was a little slow, but added that he was confident that this was improving each week. He then went on to ask Jim if he had any other vacancies since he was happy to work for him.

Jim was amazed. He had never seen such inefficient work and was surprised that he hadn't received more complaints. Using information supplied to him by Ian, he suggested that Mr Jones was deluding himself and that he couldn't allow him to continue to provide service for the company unless matters were addressed.

Eventually, he was able to persuade Mr Jones that he needed training before he should be left in charge of a pharmacy. With Ian's agreement, he arranged for Mr Jones to spend several weeks working with him to give him the chance to learn about retail pharmacy.

Official stance

There is no legal barrier to transferring from one branch of pharmacy to another since Mr Jones' qualification as a registered pharmacist is valid for industry, hospital and community work.

However, there is clearly a duty on him as a professional person to be able to cope with the job's demands. This is reflected in the requirements of Principle 5 of the Code of Ethics which relates to standards of professional competence and is specifically expanded in Obligation 5.2. It requires a pharmacist taking up a position as sole pharmacist to have substantial recent experience (within the past five years) or to undertake any necessary training. Clearly, Mr Jones did not comply with this requirement.

What about Ian and Jim's situation? Principle One of the Code states that a pharmacist's prime concern has to be for the welfare of the patient and the public. To ignore Mr Jones' performance would be condoning it and could be in breach of the ethical requirement. In addition, the company superintendent pharmacist has duties under Principle 6 to ensure the efficiency and quality of the service provided.

Clearly, Jim's actions have given Mr Jones an opportunity to pull his socks up. He had better make the most of it!

Multisymptom cold & flu relief for today's way of life

The common cold and flu viruses have always been a problem. Lifestyles are increasingly demanding; very often far too demanding to spend a day in bed. Sufferers want symptomatic relief and increasingly turn to their pharmacist for advice on self-medication. But with so many cold and flu products on the market, it's hard to choose, let alone recommend the right one.

However, research shows that sufferers' fundamental needs are similar.[1] They all want fast, effective relief of all their cold and flu symptoms – ideally in one product. One that doesn't cause drowsiness. One that is well tolerated. And, importantly, one that enables them to get on with their busy lives.

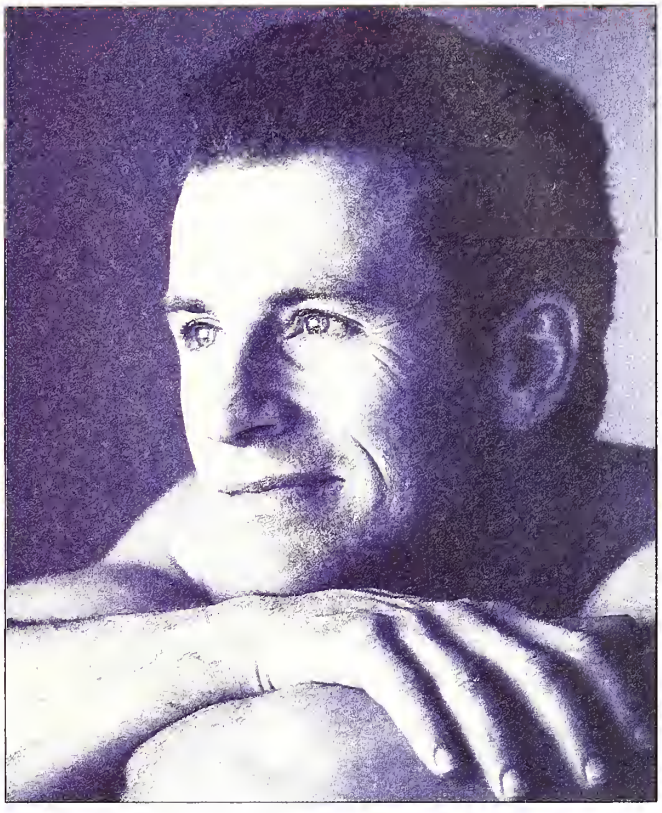
An advanced combination

There is now a modern treatment that takes advantage of the latest scientific understanding and responds to the trend towards well tolerated, effective self-medication that lets patients get on with their lives.

Nurofen Cold & Flu brings together ibuprofen's proven analgesic and antipyretic activity, and pseudoephedrine's decongestant performance, in a fast and effective product that does not cause drowsiness.

Clinical trials have shown that the combination of the two active ingredients in Nurofen Cold & Flu effectively relieve all the major cold and flu symptoms.

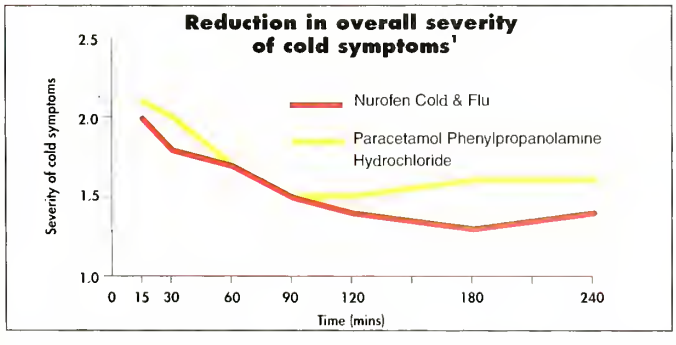
- Aches and pains ✓[2-4]
- Headaches ✓[2-4]



- Sinus pain and pressure ✓[5]
- Blocked nose ✓[5,6]
- Sore throat ✓[7,8]
- Fever ✓[9-14]
- Sneezing ✓[6].

Overall relief

Nurofen Cold & Flu has proven efficacy in reducing the overall severity of symptoms of colds and flu. In fact, in a comparative trial versus a paracetamol/-phenylpropanolamine combination, patients experienced superior cold relief with the formulation containing ibuprofen.[5] What's more, Nurofen Cold & Flu not only alleviates specific symptoms, but also aids relief of general malaise – a real advantage for those who want to get on with their lives.[15]



A well tolerated treatment

Ibuprofen is a modern well tolerated analgesic with a good safety profile in overdose. In a review involving 46,000 patients, the adverse event profiles of ibuprofen paracetamol and aspirin were compared.[16] The study found that upper GI bleeding associated with aspirin was greater than that associated with ibuprofen, and that the incidence of adverse events associated with ibuprofen were similar to that found with placebo or paracetamol.[16]

Ibuprofen has such a low toxicity in overdose that a recognised lethal dose has not been established. This contrasts with the well known toxicity of aspirin and paracetamol.[17] Pseudoephedrine is an efficacious, well tolerated non-sedating decongestant.

Overall relief on recommendation

Let Nurofen Cold & Flu relieve both you and your customers of troublesome cold and flu symptoms. With ample clinical evidence to support its efficacy, tolerability and safety, you can be confident that it is a recommendation that your customers will thank you for.

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Product Information: Nurofen Cold & Flu
Nurofen Cold & Flu: Each tablet contains 200mg ibuprofen BP and 30mg pseudoephedrine hydrochloride. **Indications:** Effective in the relief of symptoms of colds and flu with congestion, such as aches and pains, headache and feverishness, sore throats, sinusitis and blocked noses. **Dosage and Administration:** Adults and children over 12 years: Initial dose 2 tablets taken with water, then if necessary 1 or 2 tablets every 4 hours. Do not exceed 6 tablets in any 24 hours. **Precautions and Warnings:** Nurofen Cold & Flu should be avoided by patients with stomach ulcer or other stomach disorder. Asthmatics, anyone allergic to aspirin, anyone receiving regular medication and pregnant women should be advised to consult their doctor before taking Nurofen Cold & Flu. Not recommended for children under 12. If symptoms persist for more than 3 days, patient should consult their doctor. **Product Licence Number:** 0327/0060. **Licence Holder:** Crookes Healthcare Ltd, Nottingham NG2 3AA. **Legal Category:** P. **Price:** £2.49 for 12, £3.95 for 24, £5.19 for 36. Prices correct at the time of going to press

Focus on pharmacy niche

US pharmacists are waking up to the alternatives, as Tony de Nicola discovers

US pharmacists, particularly independents, are starting to focus their marketing efforts on a customer and product niche which is being broadly labelled 'health and wellness'. The combination of unrelenting pressure on prescription margins by the managed care buyers and ever-increasing competition at the retail level for the purchasing dollars of US consumers is driving this activity at a rapid pace.

The terms health and wellness have come to mean different things to different people. One of the biggest 'crossovers' is with the term 'alternative medicine'. In the classic sense, alternative medicine includes acupuncture, chiropractic and other ways to treat serious illnesses without the use of medicine. In the early days, the word 'alternative' usually meant an alternative to traditional physician and hospital-based care. This has been coupled with a focus on 'holistic medicine'.

Today, this has evolved into a broad arena, with many ways to treat disease including, but not limited to, medicinal alternatives to traditional prescription medications. Most of these products are nutritional, ranging from the core vitamins – vitamin E, vitamin C and an increasing range of antioxidant products – to the many multivitamin combination products available here.

In the US, there has been a new product focus on both herbal and homoeopathic products in recent years, borrowed from the European community. While neither of these is particularly new or different, US marketeers, in their usually exuberant, over-the-top style, have put these categories under the spotlight.

All this activity seems to have been developed and expanded during the past 18 months.

A recent visit to the National Community Pharmacists' Association Trade Exposition, held this year in Denver, Colorado, revealed no less than 20 different nutritional/wellness programmes available for independent retailers. Indeed, it seemed that for the first time in more than a decade, computer software and technology vendors were outnumbered by these programmes.

Many retailers in health, wellness and nutritional programmes say this is the OTC product and service niche of the future.

While the offerings are many and often complex, there are certain core elements which provide a common theme.

It has been proved more than once that the more products you carry and display in this particular category, the more you will sell of everyone's products. In the past, US pharmacists tended to limit their nutritional products to one or two 'franchise' vitamin lines, on the basis that consumers would buy what you carried if it was properly priced and displayed. That thinking has changed to the point where it is not unusual to see as many as five different complete lines of product (50 to 100 SKUs), plus assorted specialty products, displayed in a pharmacy which represents itself as a wellness or nutritional centre.

In addition to carrying expanded lines of vitamins, US pharmacies are now displaying a wide range of herbal medicines, as well as homoeopathic remedies, many of which are imported from Europe or the Far East. They are also carrying herbal drinks, primarily teas and, in some cases, a reasonably wide range of what we would call health foods, products previously only found in traditional health food stores like GNC (the US equivalent to Holland and Barrett). These products have become readily available as distributors have recognised the enormous potential in the pharmacy market.

Consumer information has become an essential part of these programmes. While this is often simply a variety of leaflets and brochures in the pharmacy, many pharmacists are taking the time to learn about the products and new courses of treatment available, and becoming actively involved in their sale, rather than leaving them to self-selection. This is generally viewed as an expansion of the pharmacist's role in patient counselling and pharmaceutical care. While the consumer makes no direct payment for this advice, the fact is that the profit margins on these products are substantially higher than other OTCs and prescriptions.

This has led many US pharmacists to position themselves as nutritional counsellors in the eyes of consumers, as well as other healthcare professionals.

The more sophisticated of these programmes are now including some sort of computerised 'diagnosis' of consumers' nutritional needs, coupled with the ability to monitor their progress and to recommend the appropriate product(s) necessary to deal with their illness or deficiency. While the costs remain high, early results show that this type of activity increases consumer confidence in the pharmacist's recommendations, builds the sale significantly and develops repeat visits to the pharmacy.

Many innovative pharmacists have begun to include other healthcare professionals in their programmes, primarily nutritionists, often nurses of different types and sometimes exercise or physical fitness people. Their presence in the pharmacy, for advice and consultation, has served to heighten awareness of the pharmacy as a health and wellness centre.

While few US pharmacists are totally confident of their ability to provide counselling and advice about nutritional products, others are rushing to reconfigure their stores and learn about all the products in this category. Some pharmacists, particularly those who have been in this arena for longer, have begun to focus their entire front shop on this category. They have found that sales and profits more than offset losses from not carrying traditional OTC lines

Tony de Nicola is a pharmacist and president of pharmacy consultancy A&D Associates. He has 25 years experience in community pharmacy, owning two pharmacies in New York. He founded and directed the Legend Pharmacy Co-operative, a network of 850 community pharmacies in 15 states for 13 years.

When your customers need powerful pain relief, there's no better recommendation than Nurofen Plus. It is the potent combination of ibuprofen and codeine in Nurofen Plus which ensures that it is an ideal treatment for migraine, tension headache, cramping period pain, dental pain, neuralgia, sciatica, lumbago and rheumatic pain. When extra relief is called for, recommend nothing less than Nurofen Plus. With dual action pain relief and proven tolerability, it's clear why Nurofen Plus is the fastest growing analgesic in pharmacy.

NUROFEN PLUS 24 Tablets
ADVANCED DUAL ACTION FOR POWERFUL PAIN RELIEF
ibuprofen codeine

RECOMMEND NOTHING LESS

The chairman speaks...

The Pharmaceutical Services Negotiating Committee is having a rough time. First there was the 2.4 per cent pay imposition; now there is dissent from within the Committee itself which has mushroomed into a wider revolt. Chairman Wally Dove remains unfazed

PSNC chairman Wally Dove is not impervious to the criticisms aimed in his direction. He is sensitive to contractors' grumbles, shares their frustrations, and at closed meetings around the country has been telling them how it really is. And, he says, he hasn't been getting a lot of the 'in your face stuff' that has been appearing in the press.

For those who have never been part of PSNC's negotiating team, it is hard to imagine what it is like, he says. "You are met with complete intransigence in the face of compelling argument. You have to extract the best possible deal for contractors, often deciding between the lesser of two evils."

He is adamant that his team had a coherent agenda for the last pay round, and that it was put forward as well as it could have been. "We showed the positive things pharmacists could do, but highlighted the difficulties. If we highlight the positive it is not realistic for government to continually turn resources away."

But, he admits, the Department did not specifically consider any of the proposals PSNC tabled for 1997-98. It was not, perhaps, the right time to be creative, with a change of government on the cards when talks began. "Once Labour had committed itself to Tory spending plans, we knew we had a problem. We would have been foolish to expect an easy time."

PSNC's first formal meeting in the next pay round for 1998-99 is imminent, so will he be taking a different tack next time? "It would be wrong to dismiss this year's approach," says Mr Dove. "Some of the issues we raised, like medicine management and prescription charges, are important."

However, PSNC will have to bear in mind the Department of Health's stated position that contractors cannot expect anything better than inflationary increases in the global sum for the next three to five years.

The Committee's proposals are at an early stage. It will not be easy to move away from prescription volume as a measure of work, says Mr Dove, "but that is not to say that we will not be looking to the medium term, and that may involve new structures. The Government has to be realistic, though, and recompense contractors for the work they do."

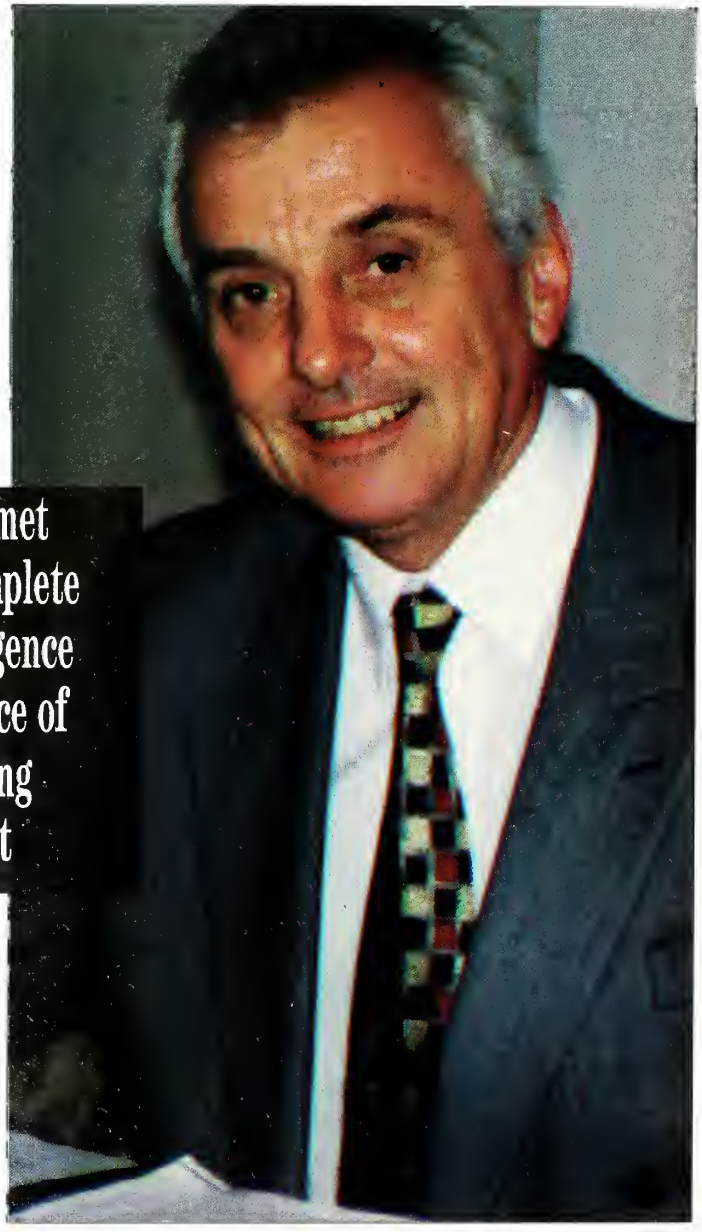
Contractors will be kept informed as proposals take shape. Underpinning PSNC's approach will be the belief that the global sum overwhelmingly represents payment for the provision of NHS dispensing services. It cannot be used to fund a creeping programme of additional work.

Personally, he does not think the current contract has reached the end of the line – "it's easy to tilt at the global sum windmill", he says. Contractors do not want a new contract, he argues: they want more money.

They are finding it difficult to find pharmacists, and trained technicians and counter staff. They cannot pay reasonable salaries, and a minimum wage could put a lot of pressure on salary budgets.

Next year, if anything, PSNC will have to be more positive and stronger, but Mr Dove feels many of the issues from the 1997-98 talks will re-emerge in the next round.

Successes? Well, PSNC did force an increased offer of 2.4 per cent from the DoH. "This was still condemned by all 25 PSNC members, which was why it was imposed. We used every conceivable argument, but ultimately it was a Treasury decision. They had a stronger influence this year than I have seen before."



You are met with complete intransigence in the face of compelling argument

The practice allowance threshold has been held at the same level, although one of the options proposed by the DoH lifted it by 50 items a month. The Committee has also resisted the devolution of any further services for local negotiation.

The Patient Pack Initiative is not a direct remuneration issue, although it will have a knock on effect. PSNC calculates that contractors will be left with £9.45 million of irreducible stock on their shelves over the introductory period, and it refuses to accept that they should have to foot the bill for it. Meanwhile, in the absence of any sensible move to implement PPI, the container allowance still exists within the global sum.

Contractors need to keep an eye on the fact that the Government has a huge majority, warns Mr Dove. "It could be one of the most radical we have seen for a long time. We cannot afford to rely on the status quo."

Remuneration for existing services needs to be protected. Contractors do not realise how much pressure there is to cut the current fee and the professional allowance, he says.

In the short term, next week's White Paper will indicate the likely direction of service changes. The Government is also expected to make clear its plans to eradicate prescription fraud in the next few weeks.

In the longer term, the control of entry regulations and the dis-

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count clawback are potential areas of trouble.

"It is imperative that we start plugging some of the holes in the law book. At the moment contract limitation underpins the integrity of the distribution network," says Mr Dove. "PSNC's policy is that contract limitation in a strengthened form is absolutely essential."

He is less forthcoming on discount clawback, saying only that the inquiry is a continuing process, and "there is increasing DoH and Treasury pressure due to general public expenditure policy and the MMC report on Lloyds".

"Pharmacy contractors are vulnerable, we are a soft touch," he believes. "We have never found an effective sanction against government." Perhaps the lever is to sell the idea that community pharmacy is not only 'liked' by the public, but expected to provide easy access to NHS services. "Any government should fear a 'post office closure' type campaign. We may be facing a diminution of service."

The differences between the PSNC and the Royal Pharmaceutical Society that grabbed the headlines earlier this year have largely been papered over for the common good.

PSNC agrees with most of the 'New Age' document, says Mr Dove, and now wants to progress beyond statements of broad principle. "We want to see professional standards raised so that pharmacy is perceived as being fit to carry out a wider range of tasks," he says.

"But we don't want to sacrifice the existing core function, especially not without having a very clear idea of what pharmacists would be doing instead and how they would be rewarded."

PSNC regards supervision as a "vital foundation". If it is weakened or removed it becomes more difficult to distinguish pharmacists from technicians.

> We even manage to be divided over a pay settlement that we all agree is unacceptable

The Patel factor

Hemant Patel's crusade for a review of PSNC's *modus operandi* is one war Mr Dove could do without, and he is clearly irritated that it has been carried beyond the confines of the Committee to LPCs.

He finds it difficult to understand why a small number of PSNC members are directing criticism at the Committee and, in effect, themselves.

"They know as well as anyone that PSNC often finds itself confronted by a brick wall. They don't have anything that will change that fact," he says.

Changes have been made to the running of the office and the operation of the Committee since he became chairman last year, and he believes PSNC, as a whole, works quite a lot better than it did. A further review would be a waste of effort.

"It's just pie in the sky to think that twiddling with the structure will result in the government paying contractors more money," is his view. And he points out that only four members voted in favour of Hemant Patel's proposals.

Mr Dove accepts that there is substantial support for Mr Patel in London and the surrounding areas. Elsewhere, with one or two exceptions, the PSNC office has no indication that there is a large groundswell in his favour.

"That does not mean we are complacent. We are the first to admit that a lot of contractors are very angry. The problem is that Hemant is deflecting fire from where it would be better directed – the Department of Health.

"As a profession we are again parading our differences in public. We even manage to be divided over a pay increase that we all agree is unacceptable."

He considers some of the slurs made against Committee members "pretty insulting". Fifteen of the 25 pharmacists on PSNC are directly elected. A further five are elected to the National Pharmaceutical Association board and nominated to PSNC after a ballot.

Only three Committee members own businesses dispensing more than 6,000 items a month: two have pharmacies which dispense under 2,000, and eight dispense between 2,000 and 3,000.

To suggest PSNC is made up of high volume contractors who want to feather their own nests is simply not true, he says. The Committee is, in fact, highly representative.

"What London LPCs should concern themselves with is making sure their elected members are putting their case effectively and coherently. London does not run the UK – in pharmacy terms London is an atypical area," says Mr Dove, adding that a working party is looking at its particular situation.

Wally Dove says he will stand for the chairman's job again next year. Perhaps politics is addictive. It's just as well, because at the moment he is getting precious little thanks for his labours.

HEALTH CHECK

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A case for prescribing

Health secretary Frank Dobson likes the idea of extending pharmacists' responsibilities. So do many pharmacists, as *C&D*'s latest business trends survey reveals

Pharmacists overwhelmingly support a much wider role that will allow them to prescribe for selected ailments and long-term medication, reports *C&D*'s business trends survey.

Some 80 per cent of pharmacists feel confident about prescribing for asthmatics. Pharmacy size influenced opinions and just 61 per cent of pharmacists with large businesses – turnover exceeding £1 million – felt confident about prescribing in this field. In contrast, 89 per cent of respondents with medium-sized businesses (£0.5–1m) have no qualms about handling these prescriptions.

Of those who are not confident about prescribing asthmatics, 55 per cent say it is because of lack of knowledge and experience and 45 per cent believe the role would infringe on the GP's responsibilities. However, 90 per cent say they could handle prescriptions for skin complaints, and 98 per cent for minor eye conditions.

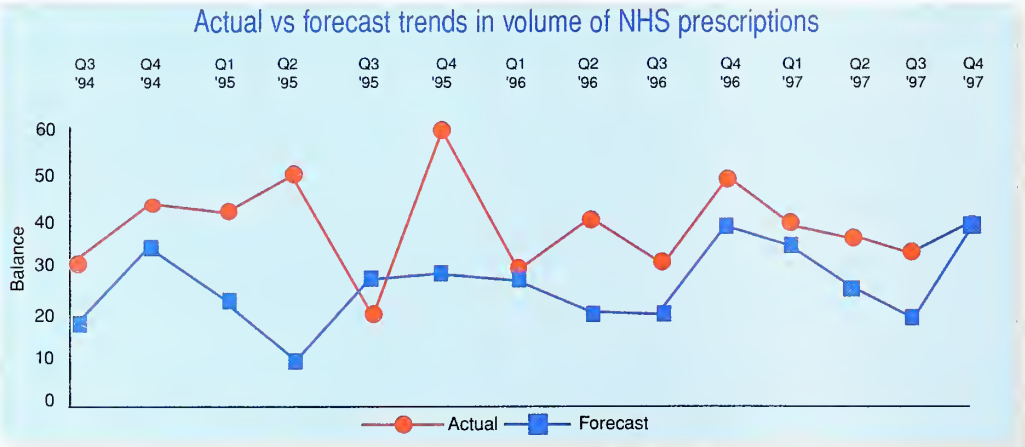
Endorsement was equally strong for repeat prescriptions, and 86 per cent of respondents are confident about repeat prescribing oral contraceptives, 87 per cent insulin, 88 per cent ostomy appliances and 97 per cent gluten-free foods.

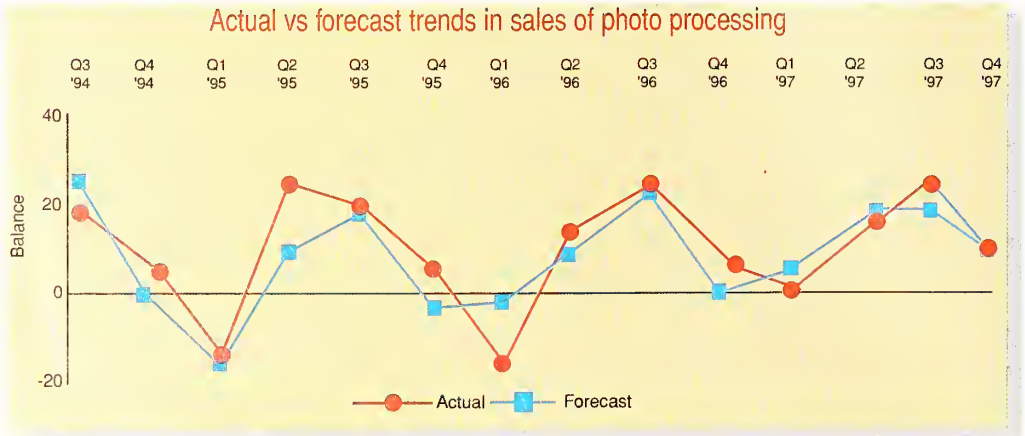
About 90 per cent of pharmacists feel they should be allowed to amend prescriptions, without referring to the GP, if they have enough information on their PMR files. The amendments they endorse include: changing the quantity to the nearest patient pack size/recognised treatment period; inserting strength of dose if omitted, substituting branded or generic equivalent if the medication prescribed is not available; substituting branded with generic equivalent unless the GP orders otherwise.

However, 80 per cent say their situations do not allow them to dispense branded drugs against generic prescriptions regularly. Although, 27 per cent in the Midlands say they can do this.

Evidence suggests that pharmacists are concentrating more on their image as healthcare providers and 46 per cent increased shelf space for OTCs, 49 per cent devoted more space to cough/cold remedies, 37 per cent to indigestion remedies, 49 per cent to analgesics and 48 per cent to vitamins/supplements.

Pharmacists are clearly thinking twice about a few below-par performers. Thirty-five per cent have cut down display space for cosmetics/fragrances, as did 37 per





Pharmacists tend to favour generic specialists when buying generics, according to *C&D*'s survey.

Thirty-nine per cent buy their products from a generics-only supplier, compared with 37 per cent from a shortline wholesaler supplying PIs and generics, and 28 per cent from a main wholesaler.

Multiples prefer a generics-only supplier – 49 per cent bought their generics from this source, whereas 35 per cent of independents did so.

Community pharmacists are more likely to opt for a shortline wholesaler supplying PIs and generics – 41 per cent choose this route.

Thirty-six per cent of pharmacists demand one service a day from their generic supplier, while 30 per cent ask for twice a day; 18 per cent once a week and 15 per cent less often.

Excluding price, 39 per cent of pharmacists say that their choice of supplier is swayed by the consistency of tablet shape/colour, and 33 per cent by the supplier's ability to provide 100 per cent of the order.

cent for sun preparations and 31 per cent for baby care products.

Dental care remains largely unaffected – 70 per cent of respondents have not changed the shelf space for this category.

Paying more attention to medicines makes sense because sales are rising. OTCs are perennial good performers in *C&D*'s surveys. The latest survey, covering July-September, is no exception. More than half of respondents report higher OTC sales, compared with last year. And an equal number expect OTC sales to rise again in October-December.

Just under half of respondents say their analgesic sales also rose and 51 per cent forecast another rise in the next quarter.

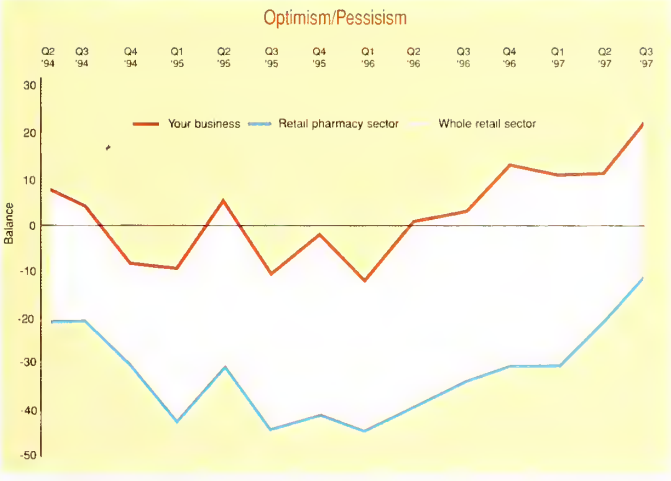
Not surprisingly, given the summer weather, 47 per cent report higher photo processing sales. More than a third believe they will rise again in the next quarter.

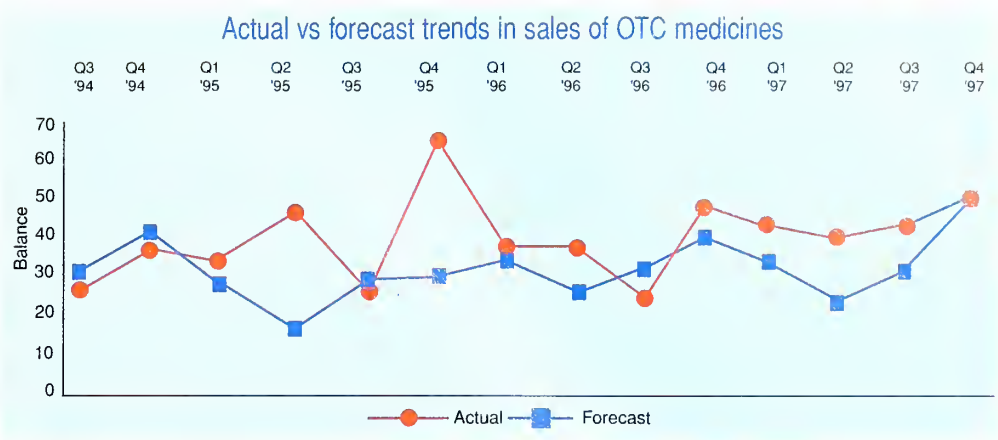
Summer holidays might explain why 37 per cent of respondents experienced higher sales of indigestion/stomach upset products. And nearly half say the sales will rise in the next quarter as customers overindulge in December.

Vitamins remain popular all year round, recording rises every quarter. Thirty seven per cent of respondents report higher sales in this category, which seems to be most popular in south England and the Midlands. Only 26 per cent of pharmacists in the North-east (including Yorkshire) report higher vitamin sales, compared with 45 per cent in the South-east (including Anglia).

Turnover (excluding NHS prescriptions) continues its drive upwards. Half of respondents say turnover rose during the quarter and 48 per cent expect it to remain higher in the next one.

Respondents performed especially well in south-west England, where 68 per cent record a rise. Their colleagues in north-west England did less well – only 36 per cent report a rise.





NHS prescriptions continue to grow. Fifty-two per cent of respondents dealt with more prescriptions and an equal number expect to do so in the next quarter. Those in south-west England were star performers – 72 per cent say prescriptions were up.

Cosmetic and fragrance sales remain relatively depressed, although there are regional variations. More than a quarter of all respondents report lower cosmetic sales, rising to 36 per cent for those in Wales. But 44 per cent of pharmacists in south-west England report higher sales.

Fragrance sales fell among 39 per cent of pharmacists, but 35 per cent expect them to rise in the next quarter as consumers buy Christmas gifts. Eighty-five per cent of pharmacists in the North-east say their sales were either unchanged or lower. But more than a third of respondents in Wales say their sales had risen.

Nearly a quarter of respondents report lower toiletry sales, although an equal number expect them to rise. Thirty per cent say baby care sales have fallen, while 24 per cent report a rise.

Just under half of pharmacists say the value of their stocks has risen and 47 per cent expect it to remain higher in the next quarter.

Margins remain at a low ebb. Forty-eight per cent of pharmacists report lower margins and 40 per cent forecast they will fall again. Those in south-west England continue to buck the trend – 24 per cent report higher margins and 20 per cent forecast the margins will be up in the next quarter.

Respondents are confident about their business prospects – 41 per cent feel optimistic about the next quarter, and 35 per cent about the next 12 months.

They are less confident about the pharmacy sector. Twenty-seven per cent feel pessimistic about its prospects over the next quarter, and 43 per cent do so over the next 12 months.

In contrast, 39 per cent feel optimistic about the retail sector as a whole over the next quarter, and a third remain optimistic over the next 12 months.

- Questionnaires were sent out to 506 members of the *C&D* retail business panel, of which 246 replied.
- Sixty-eight per cent of respondents were independents, the rest, multiples; 21 per cent were pharmacists whose turnover was less than £350,0000; 31 per cent had £350,000-£500,000; 37 per cent had £500,000-£999,999; 6 per cent exceeded £1 million; 1 per cent exceeded £2 million; and 4 per cent did not state turnover.

Government holds firm on plans for minimum wage

The level of the national minimum wage (NMW) will not be known until May next year, but the Government has confirmed that its application to full- and part-time pharmacy employees will be backed by the full force of the law.

The National Mnimum Wage Bill reveals that employers face six criminal offences if they fail to implement the law when it comes into effect in 1999 with a maximum fine of £5,000 for each case (see box).

The Government's Low Pay Commission will recommend a suitable rate in May after hearing further submissions from trade bodies such as the National Pharmaceutical Association as well as individual employers and unions, including the Union of Shop, Distributive and Allied Workers (USDAW).

Trade and Industry secretary Margaret Beckett has ruled out introducing varying rates for different industry sectors or between full- and part-time workers. It is still unclear whether measures to exempt trainees and those under the age of 26 will be included in the legislation.

USDAW is calling for a rate of at least £4 an hour for its members, which is a 25 per cent increase on the £3.21 an hour top rate pay for shop assistants, agreed with the National Joint Industrial Council (NJIC) earlier this year.

"£4 is the absolute minimum figure we are looking for. Pharmacy staff are poorly paid compared to some of our other members. Check-out staff at Tesco are paid £4.56 an hour," says a spokesman for USDAW.

The NPA, which has urged the Low Pay Commission to exercise caution when setting the NMW, says market forces dictate that many pharmacies already pay more than the NJIC rate.

"The NPA, while committed to good working conditions and benefits for all staff, is concerned that the minimum wage would hit pharmacies financially and could hurt the people it is supposed to help. Pharmacies are already suffering erosion of NHS margins and could face extra costs which force them to lay off staff or even close down altogether," it says.

Financial secretary of the PSNC, Godfrey Horridge, says the committee will not be able to calculate the full cost to its 10,500 contractors until the actual hourly minimum is known. "We can, however, put on record that we will definitely make a claim to the Government to reflect the extra cost," he says.

The *Chemist & Druggist* Business Trends Survey for the second quarter of 1997 revealed that 60 per cent of pharmacies believe that none of their staff would be affected by a minimum wage of £3.50 an hour. Some 22 per cent said it would cost one or two jobs, 9 per cent three or four and 7 per cent more than five.

The survey also indicated that slightly more independent outlets (62 per cent) than multiple branches (57 per cent) were confident that none of their staff would be affected by a £3.50 rate. Four out of 10 Pharmacies with a turnover in excess of £1m said no staff would be lost, but the same amount fear that five or more could be lost.

Low wage Bill

The National Minimum Wage Bill aims to provide a wage floor to prevent unduly low wages. The Labour Force Spring Survey conducted by the DTI indicated that the lowest paid 10 per cent of workers in the UK were earning less than £3.17 an hour. The survey confirmed that part-time and young workers were paid the least, and that retailers were among the industry sectors paying the least.

The Government will attempt to make it as hard as possible for employers to avoid paying the NMW by:

- requiring companies to keep up-to-date records showing they are implementing the new law
- appointing DTI staff to police the minimum wage, issuing employers with enforcement notices if they do not comply. Officers will be able to fine companies at a rate twice the hourly limit set by the NMW for every day of continuing non-payment
- employees will be protected by law against any retaliation or dismissal from asking for the minimum wage.

The Government will also fine companies a maximum £5,000 if they refuse or willingly neglect to implement the NMW, fail to keep records or produce false records, or obstruct an enforcement officer.

The NMW Bill defines a worker as full-time employees or those working part-time, at home or on contract.

United Norwest up to 75 shops

United Norwest Co-op has acquired its 75th branch and expects to control 100 shops by the end of next year.

The group, which has purchased 30 pharmacies in the past 12 months, will not confirm how much its acquisition spree is worth, but says there will be further "heavy investment" to eventually expand the network to 150 shops by the millennium.

The four latest acquisitions are the St Paul's Medical Centre in Blackpool, the Kenyon Pharmacy in Stalybridge and the Rawson and Gardner pharmacies in Burnley, the 74th and 75th stores to be purchased.

- National Co-operative Chemists now has 20 branches in Scotland after acquiring a private pharmacy at Alness in the Highlands.

The Alness Pharmacy, which has a turnover of around £1m, is the 20th outlet in the UK to be purchased by the operator this year, bringing its number of branches to 258.

Yardley warns over perfumes from India

Yardley London is warning pharmacists to beware of perfumes and talc imported from India.

The company is urging shops to purchase only from their Yardley territory manager or recommended wholesalers after a quantity of Chique Cologne, Talc, Pink Lace Cologne, Lace Cologne and Gold Male Fragrance manufactured in Bombay was found on sale in Yorkshire.

The company says the products, first discovered by Trading Standards officers in Rotherham and Sheffield, have been relabelled to resemble those made in the UK.

An overlabel on the back of the bottle or carton covers the Bombay address. Overlabelling is viewed as deceitful by Trading Standards because consumers cannot identify the product's origin.

Company quality and environment manager Carol Southgate says the perfumes are inferior to UK versions because they do not meet the same standards. The fragrance is different because locally sourced raw materials are used.

Yardley is unsure how many fake products are in circulation but is attempting to track down the importer by working closely with Trading Standards who have visited a number of wholesalers. "Pharmacists should return the goods to their supplier and contact Yardley," she says.

The company says pharmacists should only buy from: D&E Pharmaceutical Distributors, CBS Limited, The Argyle Rubber Co or Sangers NI.

EU to get tough over Internet medicine sales

The fight against the sale of Prescription Only Medicines on the Internet has been taken up by the European Union which is launching a network of hot lines for users to report illegal adverts.

The EU has launched an action plan to promote safe use of the Internet by encouraging member states to devise codes of conduct between access providers, content providers and operators.

The news comes just a month after the Medicines Control Agency (MCA) announced it was actively tracking down companies using the Internet to sell POMs, unlicensed medicines and unlicensed indications for licensed products in the UK.

The MCA has already said it treats information about medicines on the Internet in the same way as material appearing in the media. This means website drug advertisements are governed by the Medicines (Advertising) Regulations 1994 and the Medicines (Monitoring of Advertising) Regulations 1994 which implement directive 92/28/EEC.

The EU initiative was announced in the same week that the US technology and media industry launched a national hot line for reporting on-line crime.

Stark verdict on RPM

The abolition of Resale Price Maintenance (RPM) could bring about the reduction in community pharmacies sought by the Government, says a new report.

Verdict Research's latest study of health and beauty retailers accepts that the removal of RPM would force many shops to close, but says that a reduction in the number of outlets is needed to boost the financial performance of those that remain.

Verdict says the number of outlets should be cut by up to 3,000, from the 12,000-plus currently trading, to help the rest stay competitive in the face of tightening NHS margins and the erosion of their toiletry and beauty care business by the grocery multiples.

"It is clear that many businesses are surviving on a significantly reduced net profit and that the proprietors are receiving less salary than a few years ago. The abolition of RPM may be the last straw for hundreds of pharmacies," says Verdict.

Many independent pharmacists are resisting closure in the hope that they can sell their pharmacy licence at a premium to one of the multiples.

The strongly-worded report also warns independents in relatively good financial shape to change their attitudes and radically modify their businesses to guarantee long-term viability.

Verdict says shops must foresee how they want their business to be performing in ten years' time and produce a strategy to achieve this. The report adds that pharmacies should regularly modify their product range while those trading in the same site for more than 50 years should consider relocation.

"Pharmacists fiercely defend their independence, and too often pride in their solo status is a barrier to growth and profitability," says Verdict.

The report states that pharmacists received an extra $330m from the NHS for fulfilling prescriptions in 1996, while the health and beauty market remained vibrant with consumer spending up to over $8.9bn.

● Verdict on 'Health & Beauty Retailers' costs $890 and can be ordered by telephoning 0171-404 5042.

LIG has high hopes for Avanti condoms

London International Group (LIG) hopes the global launch of Durex Avanti will boost overall sales after unspectacular half time results.

Avanti, the world's first polyurethane condom for men, was launched in the UK in September and Italy in November.

The company says early sales in the UK are encouraging and this, along with the completion of the group's re-branding exercise in the US to unite every product under the Durex name, should fuel a further improvement in the turnover of its family planning division.

Sales in this sector for the six months to September 30 grew 6.6 per cent to $59.5m, helped by an 8.6 per cent increase in branded condom sales to $48m. The worldwide branded market is growing by up to 3 per cent a year, says LIG.

Overall operating profits were up 10.4 per cent at $13.8m, with pre-tax profits rising 13.7 per cent to $10.8m on turnover down 1.6 per cent from $158.1m to $155.6m. The company attributes this decline to currency fluctuations, particularly the strength of Sterling against other major European currencies, and says that, when adjusted, sales actually jumped by 4.6 per cent.

Surgical glove sales rose 17.8 per cent to $35.7m with strong trade reported in the UK, the US, the Nordic region and South Africa. The company's household glove business also performed well in the UK as well as Eastern Europe with sales up 13.1 per cent at $14.7m.

Exchange inquiry over share dips

Recent share trading in Glaxo Wellcome and Smithkline Beecham is being scrutinised as part of a wider investigation by the London Stock Exchange into an unusually large fall in blue chip stocks last week.

The Exchange's supervision department launched the inquiry after trading in the FTSE 100 slipped 38 points, minutes before close of trading on November 28.

Shares in SB, the sixth biggest stock by market capitalisation, lost 40p in the last 15 minutes' trading which resulted in an 8.3 per cent loss for the day. GW, which is second in the FTSE 100, was down 5.7 per cent.

The falls came in the same week that Glaxo Wellcome announced a voluntary withdrawal of its drug Romozin (see **Script Specials** p16).

Zeneca moves to reassure City doubters

Zeneca will push 87 pharmaceuticals projects through medical trials in the next five years.

The announcement represents a doubling of its research programme and was made to calm fears in the City that the company's future growth may be affected by a shortage of late-stage drugs in its pipeline.

The company confirmed that research will include work on 26 new drugs aimed at treating the five disease areas of cancer, nervous system, heart, respiratory and metabolism.

COMING EVENTS

MONDAY, DECEMBER 8

North Metropol Branch, RPSGB
School of Pharmacy, Brunswick Square, EC1, 7.30 for 8pm. 'Practice Research – is it any use?'

TUESDAY, DECEMBER 9

Southampton Branch, RPSGB
A visit to the Southampton Oceanography Centre, Empress Docks, Southampton, 7.30pm, including a lecture on the role of the unit and a visit to the Aquarium.

N Scottish Branch, RPSGB
Joint meeting with SCPPE at the Golf View Hotel, Nairn, 7.30pm. 'Adverse Drug Reactions – can pharmacists make a difference?'

WEDNESDAY, DECEMBER 10

Stirling Branch, RPSGB
Old Manor Hotel, Bridge of Allan, 8pm. 'From yaks to pharmacy, Bhutan is a land of surprises'.

Hertford Branch, RPSGB
'Kevin's Christmas Quiz' at Stevenage Borough Football Club (Stripes), 7.30 for 8pm.

Eastbourne Branch, RPSGB
Eastbourne District General Hospital, 8pm. 'Pharmacy in a New Age and report from Council'.

THURSDAY, DECEMBER 11

Lanarkshire Branch, RPSGB
8pm. 'A night with the birds'.

Glasgow Branch, RPSGB
Western Infirmary dining room, Glasgow. 'The Christmas Social and Wine Tasting – Dr James Steel, wine wizard'. Tickets cost $6.

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Central and Western England and Wales
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ABOUTpeople

Trainee dispenser is youngest ever lottery jackpot winner

Seventeen-year-old trainee dispensing assistant Stuart Donnelly of Neilston Pharmacy in Neilston, Renfrewshire, has become the youngest person to win the National Lottery jackpot.

Stuart was one of 13 ticket holders to match all six numbers in last Saturday's £25 million third anniversary draw. As a result, he won £1.92 million.

"Once the dust has had time to settle, I will make sure everyone is looked after," he said, before going on holiday.

Stuart's manager, pharmacist Lorna McEwan, found out about her trainee's good fortune on the day after the draw, and has spoken to Stuart a few times since. "I met him just after he'd been to get his cheque. He seemed more excited to have been in a chauffeur-driven limousine than about the £1.9m cheque," she says.

"His win is the talk of the village. It has certainly given us something to talk about – it's better than the weather."

L Rowland helps in shoebox lift to poor countries in Europe

Over 60 branches of pharmacy group L Rowland & Co in north-west England are collecting shoeboxes this Christmas.

The pharmacies are helping the charity Samaritan's Purse in its Operation Christmas Child shoebox campaign for the fourth year running. The charity distributes gifts to children in poor Eastern European countries, such as Bosnia, Armenia and Russia.

"There has been a terrific response to date," says company secretary Jean Hughes. Over 2,000 shoeboxes have been collected through pharmacies.

A spokesman for Samaritan's Purse says: "Rowland's help is invaluable. People are more willing to do boxes if they know they can drop them off at their chemist."

The charity has already reached its target of 300,000 shoeboxes, worth £2.4 million. These will be transported from Liverpool airport on December 15.

Staff at the AAH Healthcare Centre in Warrington have collected non-prescription medicines, stoma pouches and waterproof mattresses for Handsworth International Mission Services (HIMS), to help the homeless in Sierra Leone. AAH's credit returns supervisor Colette Lawson has organised collections for the needy since she started work at the centre, four years ago. Pictured (l-r) are Colette, HIMS' Jonathan Lang and Alex Paterson, and AAH's assistant operations manager Audrey Lambert

December's Cambridge Counterpart winner assistant Carol Whitby from the National Co-operative Chemists in Enfield was 'bubbling' with excitement at her 'fizz'-tastic champagne prize. Carol, a keen swimmer and part-time university student, is pictured with pharmacist Michael Benjamin (left) and Simon Kitts from Whitehall

Crime Beat in search of pharmacists

BBC1's prime time programme 'Crime Beat' is coming back for a fourth series, to be aired next May, and is looking for stories of successful retail crime prevention.

Production company Folio is searching for pharmacists, who use video surveillance or who have developed crime prevention schemes, to appear in the series.

Pharmacists who have footage which illustrates the effectiveness of video surveillance in beating criminals, or who have established a successful crime prevention scheme should contact Adrian Searle, in confidence, on 0171 437 6177 or write to: Crime Beat, PO Box 2002, London W1A 22L.

French pharmacists at Derby Hospital

Hospital pharmacists at Derby City General Hospital have been playing host to two Gallic guests seeking work experience on this side of the Channel.

Pharmacist Laurette Billion and pre-registration student Patricia Dutheil funded the trips themselves and came over to gain clinical pharmacy experience.

Patricia is working under supervision in the dispensary and on the wards, until Christmas.

Laurette, who has now left, has planned other work experience placements.

APPOINTMENTS

Philip Bradley

AAH Pharmaceuticals has promoted **Philip Bradley** to retail development manager. He will remain responsible for marketing the company's healthcare centre in Warrington.

Gary Torbuck has joined Arkopharma as its new UK national sales manager.

Laughton & Sons has promoted **Anne Jones** to hair care group product manager.

Carol Kolimbarides has been appointed as Mavala's southern region area sales manager. She will be responsible for the southern areas sales force.

AAH Hospital Service has recruited two IT experts, **Steve Edwards** and **Richard Allen**, to its Healthtec division to support development and training.

Kristina Adomonis has joined Novartis Consumer Health as vice-president of global licensing.

Glaxo Wellcome's group technical director **Dr Joe Blaker** has been elected as the president of the Chemical Industries Association.

Nick Hudson has joined Food Brokers Ltd as a senior national account manager.

Ann Dougan has joined private healthcare provider Cigna as UK healthcare division business development manager.

Celsis International, the microbial risk management group, is appointing **Mark Harris** as financial director.

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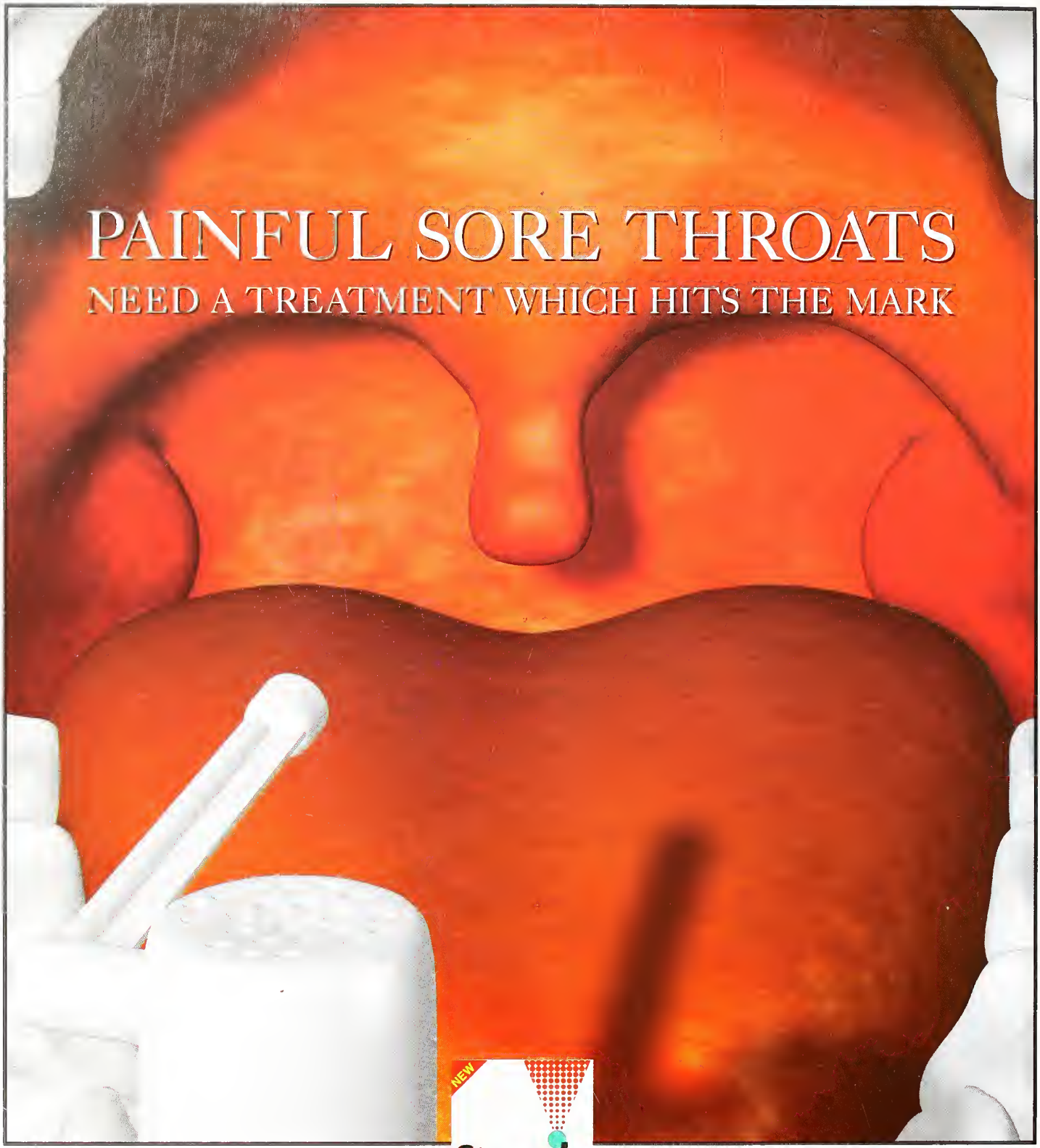

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